\			For State of Maryland / Department of Health and I  State Certificate of Death  For State  Certificate of Death	Mental Hy	- frame	006	1001
3.	* * *		1. Decedent's Name (First, Middle, Last)	2. Date of D			3. Time of Death
9	Physici /Medi		Christeene L. Blythe	April	7, 2	Year -006	4:05 PM
i	Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	1	4c. 0	County of Death	
<u> </u>			Joseph Richey Hospice Baltimore  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	O Data of B	-41-	NA	alass (State or Foreign
1	Funeral Director		553-32-0813 1 M 2 F 81 Yrs. Months Days Hours Min.	8. Date of B (Month, D	a <i>y, Year)</i>	Cou	place (State or Foreign ntry) lahoma
90	land W		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
	Marylan 1-1 show fied at	tor	Maryland Bultimore Catonsville				1X Yes 2 □ No
7	th the Mi or 28a-1	Olrec	10e. Street and Number 10f. Zip Code		-	en of What Cou	ntry?
4	eth wi	ral	20 Carters Rock Ct. 21228			JSA	
Blisthe	21215-0036 within 72 hours after deeth with the Maryland iene. iene. than "natural", or iteme 23a or 28a-1 show the Medical Examinar must be notified at	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes, Give  1 Yes, Give  1 Yes, Sive  1 Yes 2 No Specify:	pecify Yes or N o Rican, etc.)	l .	4. Race - Ameri Black, White, Specify: Wh	etc.
7	hour hour	ed p	3 ⊠Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. Decedent's Usual Occupation			d of Business/Ir	
:577	215-0036 thin 72 hours att ie. "natural", or Medical Exem	Completed	(Specify only highest grade completed)  (Give kind of work done during most of work done during	king			
0	CA B G P	Con	12 Waitress / Bartende		1	estaura	~T
_	E Sarby	Be	17. Father's Name (First, Middle, Last)  18. Mother's Nam  Flore		Hu:		
3	farylanc	J.	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru				o Code)
Deroga /	- c = N -		Jackie Berry / Daughter 20 Carters Rock Ct. C	atonsvil	le, M	10 2122	8
K	altimore, mit. Pages 1 ar partment of Hea portant: If item y injury or otha		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Loc	cation - City or T	own, State
3	timor Pages tment of tant: If it		4 Bonation 5 Other (Specify) Anatomy Gifts Registry April	7,2006	Ha	nover	MD
3	Baltimor permit. Pages: Department of H Important: If ite any injury or of pnce.		21. Signature & Funeral Service Livensee 22. Name and Address of Facility An 75.	atomy Gift 22 Conne nover:	iley Di	stry rive suit	e P
$\sim$			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician	1	Immediate Cause (Final disease or condition resulting in death)				Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				•
,	10000000000000000000000000000000000000	er	Sequentially list conditions, b. Due to [or as a consequence of] cause. Enter Underlying Cause (Disease or injury				
`	cuted and ransit	Examiner	that initiated events c.				
	68760, (Silicate be executed g physician and as the burial-transit	al Ex	resulting in death) Last Due to (or as a consequence of):				
	68760, ficate be ex physician is the burial	edical	d				
	Box (eath certi	M/u	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		2	3d. Date of deliv	rery
	, P.O. B. thet the death and by the atte	Physician/M	in the past 12 months?  1			Month	Day Year
	S, P	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco us	se contribute to	the cause of death?
	cords w require been sig	ted t		1	Yes 2	]No 3∏Pro	bably 4 Unknown
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours efter death. To the Funarel Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed		per	opsy formed?	death?	opsy findings available ompletion of cause of
	Vital	BeC	25. Was case referred to medical 26. Place of De.		2□ No one)	1 🗆 Yes	2 100
	Of V Physic this ce	ုင္		lome 5 ☐ Res		*	whospice
	On C	tlon:	27. Manner of Death  28a. Date of Injury  28b. Time of 28c. Injury at Work?  2 ☐ Accident investigation  28c. Injury at Work?  4 ☐ Yes 2 ☐ No	28d. Describe	how injury	occurred	,
	Attending the formula of the formula	flcat	3 Suicide 6 Could not be				ral Route Number,
	Division Att and or At	Certification:	4 ☐ Homicide determined building, etc. (Specify)	City or 1	own, State)		
	To the Hospital within 24 hours e To the Funaral I completely filled	dical	29a Certifier (Check only one)  Certifier (Check only one)  Certifier (Check only one)  Certifier (Check only one)  Certifier  Certifier	and dua to thurred at the time	a cause(s) , date and	place, and due	statud. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier 29c. License number		29d. Date	e signed (Monty)	. Day, Year)
			Museel S. lough D00587	17	241	07/0	6
	Ì		30. Name and address of person who impleted cause of death (Item 23a) (Type, Print)	Z.	. (	TIL	7/5/2
	01	ate	31. Date filed (Month, Day, Year) \$22. Registrar's Signature	DATT	MORE	MD	447
	Regist		APR 1 0 2006				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2 Date of Death 3 Time of Death . 2006 April 7, **Physician** 1:05P Anthony Bernard Byrd /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Civista Medical Center La Plata Charles If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 13, 1964 5. Social Security Number 6 Sex 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** M 2□ F 42 Yrs. 231-15-2793 Washington, Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits Itam 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Madical Examinar must be notified at 1 Yes 2X No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10505 Lynnewood Court 20603 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: Black 3 Widowed 4 Divorced permit. Pages 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If Itam 27 ie marked other than 'natu any injury or other traumatic event 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Barber Shop Barber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emmitt Taylor Priscilla 19a. Informant's Name/Relationship (Type, Print) Adopted 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10505 Lynnewood Terry-Mother Court Waldorf, Md. 20603 Date 20b. Place of Disposition (Name of 20c. Location · City or Town, State 20a. Method of Disposition cemetery, crematory or other place) p∰Burial 2 ☐ Cremation 3 ☐ Removal from State 4-12-06 Pleasant Valley Annandale, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chinn **Funeral** Service 5 2605 S.Shirlington Rd.Arl 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760 the attending physicien hed for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à pe 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 1 No or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Jo 1 Inpatient 2 ER/Outpatient 3 DOA After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident in by the 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4/8/06 D-52289 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nalin Mathur, MD 10 St. Patricks Drive Suite 404 Waldorf, Maryland 20603 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar APR 1 0 2006

DHMH 17 Rev 1/2001

nthony Bur

			State	State of Maryland / Depa Ce	artment of Health and rtificate of Death	Mental Hygier	4000	11003
			Registrar  1. Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physicia		Andrew	Balko		Month APRIL	)ay Year 4 2006	3:25F M
	/Medic Examin		4a. Facility Name (If not institution, give str Saint Joseph M	reet and number)	4b. City, Town, or Location of Dea		ic. County of Death Balt	imore
Ī	Funeral Director		5. Social Security Number 6. Sex 1 1 3	7. Age (In yrs. last birthday)  M 2□ F 91 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min	. (Month, Day, Yea	ir) Cou	place (State or Foreign intry) nnsylvania
			Usual Residence of Decedent	10c. City, Town or Lo	ocation			10d. Inside City Limits
	filed within 72 hours after death with the Maryland Hybjone. After then "nature!", or items 23s or 28s-f show int, the Macleal Examinar must be notified at	ō	10a. State 10b. County  Maryland N/A		ore City			1 XYes 2 No
	28a-	Directo	10e. Street and Number		10f. Zip Code	10g. (	Citizen of What Cou	untry?
	h with	al D	4205 LaSalle Aven	ue	21206		J.S.A.	
	deat	Funeral	11. Marital Status	Armed Forces?	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Amer Black, White	
30	rs after	by Fu	1 Never Married 2 Married 3 XWidowed 4 Divorced	1 ⊠Yes 2 □ No If Yes, Give WW II	1 ☐ Yes 2 ☐ No Specify:		Specify: W	hite
215-0036	72 hours "naturel",		15. Decedent's Educa	ation 16a. Dece	dent's Usual Occupation  a kind of work done during most of w		Kind of Business/I	ndustry
2 2	thin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	Sixaig		-
7	filed wil Hygien ther th	Con	12		Steamfitter 18 Mother's No	ame (First, Middle, Maid	Local 4	6
_	0 = 0 5	To Be	17. Father's Name (First, Middle, Last)  Michael	Balko	Anna		Fencha	k
ar Z	permit. Pages 1 and 2 should by Depertment of Heelth and Menta important: if item 27 ie marked eny injury or other treumatic engines.	F	19a. Informant's Name/Relationship (Typ	e, Print) 19b. Maili	ing Address (Street and Number or F			ip Code)
Σ	and 2 Belth an 27 in 27 in er tre		James Balko - Son			Baltimore, 1	MD 21234 Location - City or	Four State
Baltimore,	it of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	osition (Name of matory or other place)		•	
	it. Pa irtmen irtent: njury		4 □ Donation 5 □ Other (Specify)  21. Signature 0 Funeral Service Licenses			ril 7,2006		
Ba	Depe impo eny i		Paul I da	tool	Leonard J. Ruck,	Baltimore, Inc. 5305		
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do not en	nter the mode of dying, such as cardi	ac or respiratory arrest,		Approximate Interval Between
,	Pnysician	1	Immediate Cause (Final disease or condition	BRAIN TUMOR -			7	Onset and Death
	/Medicat Examiner		resulting in death)	Due to (or as a consequence of): ASPIRATION FINE	I IMONITA			DAYS
		e.	Sequentially list conditions, if any, leading to immediate		.UPIUHIT			Drito
2	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
, 09/	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequence of):				
00	icate be physical s the bu	dicai	d.					
ox e	eath certific attending pl	/Me	IF FEMALE: 23	c. If yes, outcome of pregnancy			23d. Date of del	ivery
Bo	death e atter id for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year
0	et the	Phys	9 Unknown	9☐ Unknown	and a bina an una succia Dant I	23a Did tohace	o use contribute to	the cause of death?
Records, I	Attanding Physician: The law requires thet the death certificate be executed reash.  cleath.  sctor: After this certificete has been signed by the attending physician and better: After this certificate as been signed by the funeral director, page 2 should be deteched for use as the burial-transit	ğ	Part II. Other significant conditions con	ributing to death but not resulting in the	underlying cause given in Part I.	1 Yes		obably 4 Unknown
S	aw requir is been si 2 should I	Completed				24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
	Physician: The lav this certificete has al director, pege 2	E O				performed	death? No 1 ☐ Yes	V
/ita	ilcian: Th certificete rector, peg	Be	25. Was case referred to medical examiner?	ospital:	1.	eath Check only one		
<del>6</del>	Physi this o	₽.	1 ☐ Yes 2 No  27. Manger of Death	28a. Date of Injury 28b. Time		Home 5 Residence		cify)
O	ding th: : After s funer	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury				
Division of Vital	or Atter after dea Director in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ural Route Number,
_	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical Ce	29a. Certifier Certifying Phys	ician: To the best of my knowledge, dealer: On the basis of examination and/or and manner stated.	ath occurred at the time, date and pla investigation, in my opinion, death oc	ice, and due to the caus courred at the time, date	e(s) and manner as and place, and due	s stated.  to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner stated.	29c. License number	294	Date signed (Mont	h, Day, Year)
	- 5 H O		(alalla	me	marin o o c		mor V-L	L. 2006
)			( ( ) A HY X N W )	1 1	D25886	4		2000
)	,7		30. Name and address of person who co	mpteted cause of death (Item 23a) (Type		V	41.00	2000
)	1	ate	30. Name and address of person who co	mpleted cause of death (Item 23a) (Type  7.6.0 1 0 SLEF  32. Registrar's Signature		MARYLANI	D 21204	2000

			1 - State Registra Amend Item		-						ental Hyg	jiene eg. No.	006	**************************************
	· ·		1. Decedent's Name (First, Middle, La								2. Date of Dea	th	Vons	3. Time of Death
	Physici /Medio		the ma P	peverly							April	2	2006	1635 M
	Examir		4a. Fecility Name (If not institution, give	e street and numb	oer)		4b. City,	Town, or	Location	of Death		4c. (	County of Dea	th
			Johns Hopkins K	bayview 1	redical	Center	Bal	tim						
	Funeral		Social Security Number     6. S	Sex 7. I□M 2XIF	Age (In yrs.	last birthday)	If Unde Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Bin	thplace (State or Foreign buntry)
	Director		406-46-1182	201	66	Yrs.					July 1	7,19	39 K	entucky
	and *		Usual Residence of Decedent  10a, State 10b, County		10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	lanyli eho	ō		ltimore				Dund	alk					1 ☐ Yes 2x No
	within 72 hours after death with the Maryland ene. then "natural", or lieme 23a or 28a-f ehow the Madical Examinational Le notified at	Completed by Funeral Director	10e. Street and Number	TCIMOLC			10f. Zij					On Citia	en of What Co	unta/2
	with	급	100. Street and realized				101. 2.1	Code			'			,
	e 23	era	8410 Kavanagh	Road 12. Was Deced	ant Ever in II	C 12	Man Door	dont of Ui		L222	oifu Van as Na		ited S	
	prod Item	Ÿ.	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Amed Forc	es?	.3.	f Yes, spe	cify Cuba	n, Mexical	n, Puerto I	cify Yes or No- Rican, etc.)	'	Black, Whit	
36	irs af	by F	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Date			1 🗆 Yes	2. No	Specify:	:			Specify:	hita
21215-0036	tura stura	ed	15. Decedent's E		***	16a. Dece	dent's Usu	al Occupa	ation		1	16b. Kin	d of Business	nite Industry
15	in 72	plet	(Specify only highest gr	ade completed)		(Give	kind of wo	rk done o	turina mos	st of workir	ng			
77	with in the in the interest of	E O	Elementary/Secondary (0-12)	College (1-4	or 5+)	D	acker					G1	ass Co	mnany
	filed Hygid other ent,	Be C	17. Father's Name (First, Middle, Last	)			CREL		18. Moth	er's Name	(First, Middle,			шрану
<u>a</u>	id be ental ked c	To B	Sherman Campb	e11						Beul	ah Bowl	ina		
Maryland	should ind Men marke umatic	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address	s (Street a	and Numb		l Route Number		Town, State, 2	Zip Code)
Š	alth a 27 le		Miss Sharon Beve	rly (Dau	hter)	19	12 Ma	rsda	le Ro	ad	Dundalk	, Ma	ryland	21222
ē,	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene it is them 27 ie marked other then "natural", or items 23a or 28a-1 show other treumatic event, the Medical Exameter ment for inclined at		20a. Method of Disposition	2	20b. F	Place of Dispo	sition (Na	me of		D	ate	20c. Loc	ation - City or	Town, State
<u>o</u>	ages ont of t: If I		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		ate	cemetery, crei	-	•		1101	2006	N/ -	441 - D	irran MD
altimore,	permit. Pages 1 and 2 shou Depertment of Health and M Important: If Item 27 is mareny injury or other treumations.		21. Signature of Funeral Service Lice		HO	lly Hi	. Name a				2006	1,1 T	date k	iver, MD
Ba	Depermine Depermine Important in procession of the procession of t		Home	ilka	me	D	uda-R	luck	Funer	ral H	ome of			nc.
		Н	23a. Part1. Enter the disease, or com	plications that cau	ised the deat	b Do not ent	7922 '	Wise	Ave.	Dui cardiac o	ndalk, I	Mary	land 7	21222 Approximate
			shock, or heert failure. List only Immediate Cause (Final	one cause on eac	h line.	• •	0. 0.0	30 0. dy	9, 54511 45	04101000	. roopiiatory air	000,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Kena	. 100	ilure	Sepa	sis_						
	Examiner				as a consec									
		4	Sequentially list conditions,	b. Pue to (or	gal In	fection of the	n	<del></del> ,						
W	ted nsit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 10	45 4 551165	1401100 017								
1	cate be executed physicien and the burial-transit	xar	that initiated events resulting in death) Last	C. Due to (or	as a conseq	uence of):								
8760,	be e licien burit	alE		,										
	phys phys the			_ d										
9 ×	requires that the death certificens igned by the ettending prould be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, outco	me of preco:	ancy								
Вох	etten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birt	h 2∐Feta ntattime of c	Ideath 3	Ectopic p					2.	3d. Date of dei Month	Day Year
o	the de	ysic	1 ☐ Yes 2 ■ No 9 ☐ Unknown	9□ Unknow		eam st	J Other (s)	оеспу)						
P.0	thet t ed by detac		Part II. Other significant conditions	contributing to dea	th but not res	ulting in the u	nderlying	ause dive	n in Part I		23e. Did tol	bacco us	se contribute to	the cause of death?
Records,	8 5 g	ρ		<b>311</b>		J		g				es 2		robabiy 4 <b>E</b> Unknown
Ö	w requir been si should	ete									-			
ě	S 2	Completed									24a. Was a autops	Sy	prior to	topsy findings available completion of cause of
<u>=</u>		ပ္ပ									1 Yes	med? 2 No	death? 1 ☐ Yes	2□ No
/ita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?							e of Death	(Check only on	e)		
Division of Vital	S . S . D	၉	1 ☐ Yes 2 ■ No	Hospital: 1 Inp		ER/Outpatier			4 🗆 NI	ursing Hon	ne 5 🗌 Reside	ence 6	□Other (Spe	cify)
ū	Jing P	i.	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of (Month,	Injury <i>Day Year)</i>	28b. Time of Injury		28c. Injury Work	at ?	2	8d. Describe ho	ow injury	occurred	
<u>si</u>	Attending it death. ector: After by the funer	Certification;	2 ☐ Accident investigation				М	101	/es 2 □	No				
<u>≅</u>	or Att	ŧ	3 Suicide 6 Could not be determined	28e. Place of	Injury - At h	ome, farm, str fy)	eet, factor	y, office		2	8f. Location (St City or Town	treet and n, State)	Number or Ru	ural Route Number,
	rei D													
	10sp 4 hou une aly fil	edical	29a. Certifier 1 Certifying PI (Check only 2 Medical Example)	nysician: To the b	est of my kno	wiedge, deati	occurred	at the tim	e, date an	nd place, a	and due to the ca	ause(s)	and manner as	stated.
	To the Hospital or Attending Ph within 24 hours eiter death. To the Funeral Director. After th completely filled in by the funeral	led	one)	and manne	r stated.					an accurre				
	To To	Σ	29b. Signature and title of certifier					c. License			2	9d. Date	signed (Mont	h, Day, Year)
	^		Dr. Marcia	Mack				Res	- (	000	1	pri	12,2	006
	2		30. Name and address of person who	completed cause					•			+		
			Dr. Aleicia Mack	4940.Eas	ern A	venue	B	altir	none	, m	2122	24		
	Sta		31. Date filed APR Day, Var200	6 82 Bec	istrar's Signa	ature								
15	Registr	rar		1	-									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Stata Registrar Certificate of Death Reg. No. U G 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year USZI Month argare 15 AM 2006 /Medical 0 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Barriew Johns Hopkins N/A more (aso Center 7. Age (In yrs. last birthday) 81 Yrs. If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 11-7-1924 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 □ M 21X F 215-22-2325 Director MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f shov Examiner must be notified at Director MD BALTIMORE ROSEDALE 1 ☐ Yes 2\No 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 1315 CHESACO AVENUE **APT 221** 21237 U.S.A. withIn 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify β 3X Widowed 4 □ Divorced WHITE "natural" Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) 11 HOMEMAKER OWN HOME y caff,

vages 1 and 2 should be file
Department of Health and Mental Hyg
mportent: if item 27 is marked
by injury or other 17 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY RICKETTS RUTH (MC DANIELS) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANNA POE/DAUGHTER 1528 ROSEWICK AVENUE ROSEDALE, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST CEM 4-14-2006 OWINGS MILLS, MD 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licenses 1211 CHESACO AVENUE ROSEDALE, MD 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 25 minutes /Medical Due to (or as a consequence of): Examiner Fa Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9□ Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page certificate Preumonio 1 Yes 2 X No Attending Physicien: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred cal Certification: 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident in by the 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 T Homicide ō within 24 hours a To the F neral pelli To the Hospital Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) HOPKING BAYVIEW CIRLS Name and address of persop who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

6

32. Registrar's Signature

Win

BALTIHORIZE

10

zenon

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** James Arthur Crue 2006 7145 Pm /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale BAITIMORE HOSPITAL FRANKLIN SQUARE If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Pave Hours Min. (Month, Day, Year) 7. Age (In yrs. lest birthday) 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** XIXIM 2□ F Yrs. 220-24-0852 Director Sept. 4, 1929 Maryland Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23= ~ nother traumette. 10b. County 10c. City, Town or Location 10d. Inside City Limits Be Completed by Funeral Director Maryland Baltimore 1 Yes 20 No Essex 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 953 Barron Avenue 21221 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1949 Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced 1950 White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Foreman Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Raymond Lamar Crue Gladys Leedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Edith Crue (Wife) 953 Barron Avenue, Essex, Maryland 21221 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/11/06 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gardens 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funyral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part Timer the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) ColiTis a Pseudomembravous DAYS Examiner Due to (or as a consequence of): Physician/Medical Examiner ANTIDIOTIC THERAPY Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown COPD ACD Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requiras that tha death certificate be executed within 24 hours after death.

To the Funeral Director; Afte complataly filled in by the fun

Be

၉

Certification:

edlcai

DR TONG JING
31. Date filed (Month, Day, Year) Registrar

29b. Signature and title of certifier

La

25. Was case referred to medical examiner?

1 Yes 2X No

27. Menner of Deeth

1 Natural 2 Accident

3 Suicide

29a. Certifier (Check only

4 I Homicide

d caus

Hospital:

5 Pending investigation

6 Could not be determined

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

1) Yes 2□ No

D63216

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

Yes ZLINO

28d. Describe how injury occurred

30. Name end address of person who complete of death (Item 23a) (Type, Print) FRANKLIN SQUARE DR. BALTIMORE Md 21237

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature APR 1 0 2006

1 Unpatient

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1555 ß CONKLIN 3 2066 MUTH APRIL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALMORE JOHNS HOPKINS BAYNEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 20XF Days Hours Months Yrs. 244-14-4317 81 Director June 8,1924 North Carolina Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes ŽŤNo Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8451 Kavanagh Road 21222 United States death ! Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ģ 3 ☑ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Steel Industry 12 Years Clerical ulth and Mental Hygid 27 is marked other r treumatic event, is other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent; if Item 27 is marked oth any injury or other treumatic event <u>spre.</u> 17. Father's Name (First, Middle, Last) Ukn. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2705 Mede Ct. Fallston, Maryland Mr. Albert Conklin (Stepson) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 4/6/2006 Towson, Maryland 21. Si nature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPTIC SHOCK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, it any, loading to mind date cause. Enter Underlying Cause (Disease or injury that initiated events as a nonsequence of) or Attending Physicien: The law requires that the death certificate be executed after death. burial-transit physician and resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical the ed by the attending detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part §. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown OBSTRUCTIVE PULMONARY Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an autopsy performed? 1K Yes 2 □ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 🗷 Natural s after dea. 5 Pending 1 TYes 2 No investigation 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral D 29a. Certifier 1 🔾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified -MD 1006 30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) BALTIMARE DENISE GONZALEZ 4940 EASTERN AVENUE 32 negistrar's Signature 31. Date filed (Month, Day, Year) State APR 1 0 2006 Registrar

77%	100	100	100		1	. 100	100	-23
1	1.1	1 1	1	i	- 1	1.1	1.1	13
P. Carrier	3 8	1 1	E B		- 2	1 1	3 1	3 3

06-02299			Pleas	se Type or	Print in I	Black Inde	lible Ink			
Charles, Gwyn			State of Mary	<i>y</i> ,				vaiene	200	10 1100
		1- For State		•	rtificate of					0 1100
Physici	an/	Registrar  1. Decedent's Name (First,	Middle,Last)					2. Date of Death		3. Time of Death
Medical Exami		C				Charl	08	Month April 3, 200	Day Year )6	9:51
		Gwyn 4a. Facility Name (if not ins	titution, give street and r	iumber)	4	b. City, Town, or L	Location of Death		4c. County of E	Death
$\times$		330 East Belvede	re Avenue Apt. 2			Baltimore Ci	ity			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year		s. 8. Date of Birth	(MM/DD/YYYY) 9	9. 8irthplace (State or Foreig
Director		214-68-236 Usual Residence of Deced		49	Yrs.	Months Days	Hours Min	08 31	. 56	Country) M D
any		10a. State 10b. Co	unty	10c. City	Town or Location	on				10d Inside City Limits
ınd show	<u>_</u>	MD N	A	Ba	ltimore	2				1 X Yes 2 No
laryla	ector	10e. Street and Number	A	Du.		10f. Zip Code		100	g. Citizen of What	Country?
the Na or 2	Ē	330 B+ De	ladama A	***		21	212		U.S.	λ
with 18 23 see not		330 East Be		ve ecedent Ever in U	.S. 13. Wa	Decedent of Hisp		pecify Yes or No-		Merican Indian, 8lack,
eath • item	Funeral	1 Never Married 2	Warried RF	Forces?		es, specify Cuban,			White, e	
fter d	ΥĒ	3 Widowed 4 X	☐ Divorced If Yes, Give Yes		1	Yes & No	specify:		Specify: E	Black
ours a atura	d by	15. Decedent's Education	or Dates: (Specify only highest gra	ade completed)		's Usual Occupation	on (Give kind of v	work done	16b. Kind of Busin	ess/Industry
72 hc	Completed	Elementary/Secondary (	0-12) College	(1-4 or 5+)	during most of v	vorking life. DO NO	OT use retired)			
036 ithin ne. r tha	E E	12th grade	2yr	S	Uı	nemploy	ed		Unemp	oloyed
5-0 led w othe	ပိ	17. Father's Name (First, M	iddle, Last)			1	8. Mother's Name	e (First, Middle, Ma	aiden Surname)	
21. be fill ntal F	Be	Willie Cha	rles				Lula M	ae Whit	e	
ould Me	ပ	19a. Informant's Name/Rel	ationship (Type, Print )		19b. Mailing	Address (Street	and Number or I	Rural Route Numb	per, City or Town,	State, Zip Code)
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Flaulth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show. injury or other traumatic event, the Medical Examiner must be notified at once.		Toni Derric		20b.		tion (Name of cem			more, N 20c. Location - Ci	
Pages ent of nr: I		1 X Burial 2 Cred 4 Donation 5 Ott					<u>.</u> 4/1	12/2006	0	~ Mill~ Ma
altir mit J vartmo oorta ury ou		21. Signature of Funeral Se		Gā	22. N	Forest	C 4/」 of Facility	13/2006	Owing	s Mills,Md
Dep		Mon H	- K. an	0.)	Mar	ame and Address Ch F/H	West	D-1+i	mara Ma	21215
Physician /Medical		23a. Part I. Enter the disea failure. List only one	ause on each fine.		. Do not enter th	e mode of dying, s	such as cardiac o	or respiratory arres	more Md st, shock, or heart	Approximate Interva 8etween Onset and
Examiner		Immediate Cause (Final di or condition resulting in de	ath) Due to (or as	arrhythm	of):					Death
	Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying C	Due to (or as	falmator		changes				
	Eg.	(Disease or injury that initial events resulting in death)	ated C.	a consequence of	of):					
executed an and al - transit		overno recuming in accum,	d.							
O, be exectsician ar	edical	X UNPENDED	AMENDED	item#23a	a,b,27,per	ME,C855,5/	/10/06 TT			
cords, P.O. Box 68760, aw requires that the death certificate be executed has been signed by the attending physician and 2 should be detached for use as the burial - transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnal past 12 months?  1  Yes 2 ✓ No 9	nt in the 1 Live	gnant at time of de	2 Fet	al death 3 [ner (Specify)	Ectopic pregna	ancy	23d. Date of de Month	livery Day Year
O. E tribe of by the ached		Part II. Other significant of			esulting in the u	nderlying cause gr	iven in Part I	23e. Did tob	acco use contribut	te to the cause of death?
P.( es that igned	d by		-			0				Probably 4 Unknown
cords, P.O. law requires that the has been signed by 2 should be detack	pleted							24a. Was ar		re autopsy findings available r to completion of cause of

Division of Vital Reco
To the Hospital or Attending Physician: The law
within 24 hours after death.
To the Funeral Director: After this certificate has
completely filled in by the funeral director, page 2 s

Suicide Homicide 29a. Certifier (Check only

Medical Certification: To

1 Yes 27. Manner of Death

1XX Natural

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.

Accident

25. Was case referred to medical examiner?

2 🗸 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

2 No

5 Pending

6 Could not be

Investigation

determined

Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

28a. Date of Injury (Month, Day, Year)

29c. License number O.C.M.E.

26. Place of Death (Check only one)

28c. Injury at Work?

1 Yes 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City

April 4, 2006

1 Yes 2 No

Other Nursing Home 5 Residence 6 Other: Scene

or Town, State)

28d. Describe how injury occurred

me and address of person who completed cause of death (Item 23a)

State 31. Date filed (Month, Day, Year)

APR 1 0 2006



Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc.

**ORIGINAL** 

Registrar

DHMH 17 Rev 1/2001 OCME 10/2003

			For State Registrar	State	of Mar	yland / Dep <i>Ce</i>	artment			and M		iene	6		9
	* 3		Decedent's Name (First, Middle,	Last)				-			2. Date of Deat Month	th	Year	3. Time of	Death
	Physicia		Robert	Į	A.	C	look				April	6, 2006		8:30	$P^{M}$
	/Medic Examin		4a. Facility Name (If not institution,	give street and	number)		4b. City,	Town, or i	Location o	f Death		4c. County	_		
			2113 Maple Road	l				gemei				Ba	ltim	ore	
	Funeral			3. Sex 1 <b>⊠</b> M 2⊡ I		In yrs. last birthday	Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day July 31	Year 027	9. Birthp Cour	place (State o	r Foreign
1	Director		394-20-5474	TAN ELL	<u> </u>	78 Yrs.				]	JULY 31	, 1921	Wisc	onsin_	
	and w	}	Usual Residence of Decedent  10a. State 10b. County		1	Oc. City, Town or L	ocation						1	Od. Inside Cit	ty Limits
	Manyl 1 sho	ō	Maryland Baltin	nore		Edgeme	ere							1 🗆 Yes	2 💢 No
	the t	rect	10e. Street and Number				10f. Zip	Code			1	Og. Citizen of V	What Cour	ntry?	
	3a or	ā	2113 Maple Road					2121	9			USA	A		
	death ms 2	Funeral Director	11. Marital Status		Decedent Event Forces?	er in U.S. 13.	Was Deced	lent of His	spanic Orig	gin? (Spe	cify Yes or No-		e - Americ	can Indian,	
9	after or its	E	1 Never Married 2 Marrie		es 2 No Give		1 ☐ Yes 2	_	Specify:	i, i doito	moan, o.c.,	Specifi			
ဗ္ဗ	72 hours after death with the Maryland neturel', or Items 23s or 28s-f show Jeal Exercine in unit be notified at	d by	3 ☐ Widowed 4 X Divorced	Year	or Dates:								AATTT		
21215-0036	"net	Completed	15. Decedent' (Specify only highest	Education grade complet	ed)	(Giv	edent's Usua e kind of wor DO NOT us	rk done di	uring most	t of worki	ng	16b. Kind of B	usiness/fn	dustry	
12	within lene. then	d mo	Elementary/Secondary (0-12)	Colleg	ge (1-4or 5+)		arpent	ŕ				Carpent	ter II	nion	
g 5	e filed within al Hygiene. I other then " vent, the Ma	Ö	10 Years 17. Father's Name (First, Middle, L	ast)			прене		18. Mothe	r's Name	(First, Middle,				
an	Mental Mental arked o	To Be	Oscar Cook								Schluet	er			
Maryland	A DEE	-	19a. Informant's Name/Relationsh	p (Type, Print)		19b. Mail	ing Address	(Street a	nd Numbe	er or Rura	l Route Number	r, City or Town,	State, Zip	Code)	
Ž	is 1 and 2 sift Health ar item 27 is other trau		Rose Marie Beac	hy Dau	ghter	2113	Maple	Roa	id, E	dgeme	ere, Mar	yland	2121	9	
Jre,	of He of He item	1 1	20a. Method of Disposition	3 Demoval fr	om Stato	20b. Place of Disp cemetery, cre	osition (Nan	ne of ther place	9)	Apri.	late 7,	20c. Location	City or To	own, State	
im	Page ment: H ury o		1 ☐ Burial 2 🏹 Cremation 4 ☐ Donation 5 ☐ Other (Sp		OIII State	Bayview	Cremat	cory	į	2006		Baltimon	re Ci	ty, MI	).
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Sign, ture of Funeral Service L	icensee		4	Connel 7110 S	d Address	s of Facility unera ers Po	al Ho	ome Of I Road, I	Dundlak Dundalk	P.A.	21222	
			23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications the	nat caused th	e death. Do not ei								Approximate Interval Bet	ween
	Physician		Immediate Cause (Final disease or condition	A	1		mti	ic Ca	onde	ova:	scylar	121300	ase	Onset and I	Death
15%	/Medical		resulting in death)	Due		consequence of):								7-	
	Examiner		Sequentially list conditions,	b											
4	pe sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due	o to (or as a	consequence of):									
1	xecut and	Examine	that initiated events resulting in death) Last	c	o to (or as a	consequence of):									
8760,	death certificate be executed e attending physicien and of for use as the burial-transit														
687	ificate g phy: as the	edic		- U.											
Вох	leath certifica attending ph	N/	IF FEMALE: 23b. Was decedent pregnant		, outcome of		□Ectopic pr	eanancy.					te of deliv	•	
	death	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□P	regnant at ti		Other (sp					Mo	onth	Day	Year
P.0	at the de I by the a	hys	9 Unknown								00- 0-44-	h			do o the ?
	law requires that the es been signed by the 2 should be detache	ρχ	Part II. Other significant conditio	ns contributing	to death but	not resulting in the	underlying c	ause give	en in Part i		1 TY	bacco use con	3 ☐ Prol	40	Űnknown
Vital Records,	w requir been si should	Completed													4
3ec	e law hes b	mpi									24a. Was a autop perfor	sy	prior to co death?	opsy findings ompletion of c	available ause of
a	Th ete pag										1 Yes	2 No	1 🗌 Yes	21 No	
Z:	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		a (7 5 8 %)		Othe	Ar:		n (Check only of		(0	£.1	
of	Physic this aral di	. To	1 Yes 2 No 27. Manner of Death	28a. D	1 🗌 Inpatient ate of Injury	28b. Time		28c. Injury Work	4 🗀 🕅	ursing Ho	28d. Describe h	ence 6 Oth		19/	
O	Attending or death.  ector: After by the funer	tion	1 Natural 5 Pending 2 Accident investig		Month, Day	Yea <i>r)</i> Injury	м		<br Yes 2 □	No					
Division	l or Attendi after death. Director: A in by the fu	ifice	3 Suicide 6 Could n	nod   208. F	Place of Injur	y - At home, farm, s	treet, factor	y, office			28f. Location (S City or Tow		ber or Rur	al Route Num	iber,
Ō	s afte al Dir	Certification:	4 D Normoles		diang, otc.	(Opocny)									
	To the Hospital or Att. within 24 hours after de To the Funeral Direct completely filled in by the	edicai	29a. Certifier 1 Certifyin (Check only 2 Madical I	xaminar: On t	o the best of he basis of e manner state	my knowledge, de examination and/or ed.	ath occurred investigation	at the time, in my of	ne, date ar pinion, dea	nd place, ath occur	and due to the ored at the time, or	cause(s) and m date and place,	anner as s and due t	stated. to the cause(s	s)
	within To th compl	Me	29b. Signature and tale of certifier		-		29	c. License	e number	£ **		29d. Date signe	ed (Month,	Day, Year)	
	3	_	he hatt	MAD	DeF	vtu	1	15	86	67		April	7.	2006	>
	6	-	30. Name and address of person	who completed	cause of de	ath (Item 23a) (Typ	e, Print)	NI	1	, î	(01)	N.	1 -	in	3
	Y		thilip Mil	idello,	140	6 Trim	she h	Will (	VLL	-41	nenteril	6,14	()	110	13
No.	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	nne 🌡	registrar	's Signature	and I								

Physici	386.	Decedent's Name (First, Midd:					2	Date of Dea	Day	Year	3. Time of Death
/Medic	al	Eleanor	Combs	as)	4b City	Town, or Location	on of Death	MR 4	4c COURT	y of Death	5 5 5
Examir	er	4a. Facility Name (If not institution	Jeneral L	Josnital.	200	timore	0 (1)	fy	10.002	,	
Funeral		5. Social Security Number		Age (in yrs. last birtho	(ay) If Under Months	1 Year If Und Days Hour	der 24 Hrs. 8	Date of Birth (Month, Day	Year)	9. Birth	place (State or Foreign
Director		231-11-8608	1 ☐ M 2 🔀 F	<b>43</b> Yrs	5. MOITH	Days	0	9/10/19	962		ginia
25		Usual Residence of Decedent  10a. State 10b. County	/	10c. City, Town o	r Location						10d. Inside City Limits
Losilliso a	Į.	MD		Balti	more						1 <b>X</b> Yes 2□No
	irec	10e. Street and Number			10f. Zip			1	0g. Citizen of	What Cou	ntry?
	Funeral Director	1625 North A	venue			207			USA		
	nuel	11. Marital Status	12. Was Decede Armed Force	nt Ever in U.S.	<ol> <li>Was Deced</li> <li>If Yes, spec</li> </ol>	ent of Hispanic ify Cuban, Mexi	Origin? (Speci ican, Puerto Ri	y Yes or No- can, etc.)		ice - Ameri ack, White	ican Indian, , etc.
	by F	1 ☐ Never Married 2 Mar 3 ☐ Widowed 4 ☐ Divorce	II YAS, Latva		1 ☐ Yes 2	No Spec	city:		Spec	ity: Bl	ack
			nt's Education	16a. D	ecedent's Usua	I Occupation	nost of working		16b. Kind of	Business/Ir	ndustry
	Completed	Elementary/Secondary (0-12)	est grade completed)  College (1-4c	or 5+)	fe. DO NOT us	e retired)	nost of working		Cafata	ria/	Schoo1
		12. Father's Name (First, Middle,	( ant)		ook	18 14	other's Name (	First Middle			SCHOOL
	Be	William Gardn					Sarah M			1110)	
	ဥ	19a. Informant's Name/Relation			Mailing Address	(Street and Nu				n, State, Zi	p Code)
		Sarah Ward (m	other)	20	3 Piner	oint Dr	rive, H	eathsv:	i11e, <b>V</b>	A 22	473
		20a. Method of Disposition 1 ■ Burial 2 □ Cremation	3 Demoval from Str	20b. Place of D cemetery,	crematory or o	ther place)	Da		20c. Location	-	
		4 Donation 5 Other (		Zion B	-	Church			Lottsl	٠.	
once.		21. Signature of Funeral Service  Berry 0.		er DVR	22. Name an Berry	O. Wadd	ly Fune:	caster ral Ho	, VA 22 ne, 678	2503 34 Man	ry Ball Rd
		23a. Part1. Enter the disease, of	or complications that caus	sed the death. Do not							Approximate Interval Between
n		shock, or heart failure. Lis Immediate Cause (Final	t only one cause on each	abolia	And	105/5					Onset and Death
an al		disease or condition resulting in death)	a. Due to (or	as a consequence of)	1 1 010	(	/ 0.				
r		Sequentially list conditions.	b. HCU	te he	nal	rari	ure				
ı	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of)	This						
	Kan	that initiated events resulting in death) Last	c. Due to lot	as a consequence of)	-						
	1.3										
			d								
	cal		d								
	cal	IF FEMALE: 23b. Was decedent pregnant		h 2 Fetal death	3 □Ectopic pr					ate of delin	•
	cal	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth	h 2 Fetal death at at time of death	3 □Ectopic pr 5 □ Other (sp						•
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	h 2 Fetal death at at time of death n	5 Other (sp	ecify)	art I.	23e. Did to		Month	•
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	h 2 Fetal death at at time of death n	5 Other (sp	ecify)	art I.			Month ntribute to	Day Year the cause of death?
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	h 2 Fetal death at at time of death n	5 Other (sp	ecify)	art I.	1 □ Y	ibacco use co les 2 □ No	ntribute to	the cause of death?  bably 4 Dunknown
	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	h 2 Fetal death at at time of death n	5 Other (sp	ecify)	art I.	1 Y 24a. Was autop perior	bacco use co	ntribute to	the cause of death?  bably 4 Unknown  topsy findings available ompletion of cause of
	e Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant condit	1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown tions contributing to deat	h 2 Fetal death at at time of death n	5 Other (sp	ause given in Pa	art I.	1 Y 24a. Was autop perfor 1 Yes	bacco use co	ntribute to  3  Pro  . Were autiprior to codeath?	the cause of death?  bably 4 Unknown  lopsy findings available ompletion of cause of
	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant condit  25. Was case referred to medic examiner? 1 Yes 2 No	1 Live birth 4 Pregnan 9 Unknown tions contributing to deat  Hospital: 1 Inp	h 2 Fetal death it at time of death in the time of death in the time of death in the time of time of the time of time	5 Other (sp	ause given in Po	Place of Death	24a. Was autop perfor 1 Yes  Check only on 5 Resident	bacco use co les 2 No an 24t sy med No re)	ntribute to  3  Pro  . Were autorior to codeath? 1  Yes	the cause of death?  bably 4 Unknown  topsy findings available ompletion of cause of
	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  Part II. Other significant condit  25. Was case referred to medic examiner? 1  Yes 2 No  27. Manner of Death 1  Natural 5  Pend	1 Live birth 4 Pregnan 9 Unknown tions contributing to deat  Hospital: 1 Inp 28a. Date of (Month,	h 2 Fetal death it at time of death in the time of death in the time of death in the time of time of the time of time	5 Other (sp he underlying c  atient 3 DC ury	ause given in Pa	Place of Death (	24a. Was autop perfor 1 Yes  Check only on 5 Resident	ibacco use co res 2 No an 24t sy med 2 No	ntribute to  3  Pro  . Were autorior to codeath? 1  Yes	the cause of death?  bably 4 Unknown  topsy findings available ompletion of cause of
	To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	Hospital: 1 Inp  28a. Date of 1 (Month, tigation denote) 28e. Place of	th but not resulting in the but not resulting	5 Other (sp the underlying c tatient 3 Dome of ury M	26. P  26. P  Other: Work? 1 □ Yes 2	Place of Death   Nursing Hom   28	1 Y Y 24a. Was autop performed to the control of th	es 2 No	ntribute to  3 □ Pro  Were autriprior to c death?  1 □ Yes	the cause of death?  bably 4 Unknown  topsy findings available ompletion of cause of
	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  Part II. Other significant condit  25. Was case referred to medic examiner? 1  Yes 2 No  27. Mannerof Death 1  Matural 5 Pend 2  Accident 3  Suicide 6 Coulc	Hospital: 1 Inp  28a. Date of 1 (Month, tigation denote) 28e. Place of	h 2 Fetal death it at time of death in the time of death in the time of death in the time of time of the time of time	5 Other (sp the underlying c tatient 3 Dome of ury M	26. P  26. P  Other: Work? 1 □ Yes 2	Place of Death   Nursing Hom   28	24a. Was autop perfor 1 Yes  Check only o. e 5 Resided. Describe h	es 2 No	ntribute to  3 □ Pro  Were autriprior to c death?  1 □ Yes	the cause of death?  bably 4 Onknown  topsy findings availabl ompletion of cause of  2 No
	Certification: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant condit  25. Was case referred to medic examiner? 1  Yes 2 No  27. Mannerof Death 1  Matural 5  Pend inves 3  Suicide 6 Coulc deter  29a. Certifier 1  until	al Hospital: 1 Inp 28a. Date of I (Month, tigation d not be mined 28e. Place of building and Physician To the being Physician Physic	th 2 Fetal death in at at time of death in the tat time of death in the time of time of the time of time of the time of the time of tim	5 Other (sp he underlying c  atient 3 DC ne of ury M n, street, factory	ause given in Pa	Place of Death Nursing Hom 26 2 No 26	24a. Was autoperformed autoper	ibacco use co	ntribute to  3   Proc.  Were autoprior to codeath? 1   Yes  ther (Specurred	the cause of death?  bably 4 Unknown  topsy findings available ompletion of cause of 2 No  wify)
	Certification: To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant condit  25. Was case referred to medic examiner?  1  Yes 2 No  27. Mannerof Death 1  Matural 5 Pend inves 3  Suicide 6 Could deter  29a. Certifier (Check only one)	al Hospital: 1 Inp 28a. Date of ling tigation of mined 28e. Place of building ing Physician To the basiand manner.	th 2 Fetal death at at time of death at at time of death and the but not resulting in the but no	atient 3 DO Do ne of ury M Do not restricted or investigation	26. P  26. P  A Other: 4  Work? 1 Yes 2  7, office	Place of Death   Nursing Horn   28   2   No   28   2   No   28   2   No   28   2   No   28   No   28   No   No   No   No   No   No   No   N	24a. Was autoped performed by the series of	bacco use co	Annth  Annthibute to all prior to c death?  There is there are the control of the	the cause of death?  shably 4 Dunknown  topsy findings available ompletion of cause of 2 No  trify)  ral Route Number,
	To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant condit  25. Was case referred to medic examiner?  1  Yes 2 No  27. Mannerof Death  1  Natural 5 Pend inves  3  Suicide 6 Could deter  29a. Certifier 1  urill, (Check only 2 Medica	al Hospital: 1 Inp 28a. Date of I (Month, tigation of not be mined 28e. Place of building ing Physician To the basi and manner ier	th 2 Fetal death at at time of death at at time of death and the time of death and time of death at time of death and time of	be underlying come of ury M attent 3 DC Me of ury M and street, factory or investigation 296	ause given in Pa	Place of Death   Nursing Horn   28   2   No   28   2   No   28   2   No   28   2   No   28   No   28   No   No   No   No   No   No   No   N	24a. Was autoperfolion of the control of the contro	ibacco use co	Annth  Intribute to 3 Proc.  Were authorized to death?  1 Yes  When a to the prior to the death?	the cause of death?  bably 4 Unknown  topsy findings available ompletion of cause of  2 No  wify)  ral Route Number.
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant condit  25. Was case referred to medic examiner?  1  Yes 2 No  27. Mannerof Death 1  Matural 5 Pend inves 3  Suicide 6 Could deter  29a. Certifier (Check only one)	Hospital: 1 Inp  28a. Date of I full find the mined 28e. Place of building and manner ier	th 2 Fetal death in at at time of death in at at time of death in the time of the time of time of the time of time	atient 3 DC ne of ury M n, street, factory Jan Street, factory 296	26. P  26. P  A Other: 4  Work? 1 Yes 2  7, office	Place of Death   Nursing Horn   28   2   No   28   2   No   28   2   No   28   2   No   28   No   28   No   No   No   No   No   No   No   N	24a. Was autoperfolion of the control of the contro	bacco use co	Annth  Intribute to 3 Proc.  Were authorized to death?  1 Yes  When a to the prior to the death?	the cause of death?  bably 4 Unknown  topsy findings available ompletion of cause of  2 No  wify)  ral Route Number.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 51 2006 JACK COOPER EDWIN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SPRING SILVER MONTGOMERY CROSS HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 0 36 LOOD MARYLAND Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location ir then "naturei", or itema 23a or 28a-f ehov the Madical Examiner must be notified at 1 XYes 2 □ No WD Directo HOWARD LAUREI 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number USA 2072 9630 BARREL HOUSE Completed by Funeral 14. Race · American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) none none none of Heelth and Mental Hygie litem 27 is marked other r other traumatic event, II 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 end 2 should be JACQUELINE ROBINSON HENRY JENKINS COOPER ဨ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) pertment of Heelth a socient: if item 27 is / injury or other trace CROSS HOSPITAL 1500 FOREST GLEN RD SILVER SPRING MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 ♥Other (Specify) in state 21. Signature of Fundal Service Licensee

Ronald S. Water Trector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 any i 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) PREMATURIT **Physician** EXTREME /Medical Due to (or as a consequence of): Examiner ABRUPTION PLACENTAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine nding physicien and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav jo 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an certificate has t irector, page 2 s autopsy 2 No 1 ☐ Yes 26. Pface of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) within 24 hours efter death.

To the Funeral Director: After thi completely filled in by the funeral 28c. fnjury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licanse number 29b. Signature and title of certifier D37186 Due 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SPRING MD 9801 GEORGIA AVE SILVER NORMAN

Registrar DHMH 17 Rev 1/2001

State

BRAD

APR 1 0 2006

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Andre J. Chaney
06–1889
AKG

1- Str.
Physician
/Medical
Examiner
490
Funeral
5. Social

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mentel Hyglene. Importent: if item 27 le marked other than "naturel", or Items 23a or 28e-1 ehow any injury or other traumatic event, the Madical Examinational be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Phyeiclan: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 Decedent's Name /				Certific	ate of Dea	aur		Reg. No.		
Andre J.	First, Middle, Last Chaney	1)					2. Date of Do Month March	Day	2006 Year	3. Time of Death 4:11 A
4a. Facility Name (If no		street and number)		4b. 0	ity, Town, or Loca	ation of Dea	ath	4c. (	County of Dea	th
4900 Ritc	hie High	way RM 2	12		Brooklyn			Ar	ne Aru	nde1
5. Social Security Num	nberunk 6. Se		e (In yrs. last bir 39	Yrs. If Ur Mont		Jnder 24 Hr ours Mir		av. Year)	9. Bird	thplace (State or Forei buntry) un
Usual Residence of De	ecedent 10b. County		10c. City, Town	n or Location						10d. Inside City Limit
MD	Anne Aru	ındol	R.r.	ooklyn						1 ☐ Yes 2√☐ N
10e. Street and Number		ilider	DI		Zip Code			10g Citiz	zen of What Co	ountry?
		wy Rm 212		101	2122	5		log. Oill	USA	Sumy.
11. Marital Status	unk	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was D	scedent of Hispan specify Cuban, M	nic Origin?	(Specify Yes or N	10-	14. Race - Ame Black, Whit	
1 Never Married 3 Widowed 4		1 Yes 2 1 If Yes, Give Year or Dates:	vo unk			exican, ruc	nto moun, sto.,		Specify: W	
1! (Specify	5. Decedent's Edi only highest grad	ucation de completed)	16a.	(Give kind o	Jsual Occupation f work done during Tuse retired)		unk orking	C 16b. Kir	nd of Business	/Industry un
Elementary/Second unk		College (1-4or 5 ink	5+)		7 230 76(1100)					
17. Father's Name (Fi	irst, Middle, Last)				unk 18.	Mother's N	ame (First, Middle	e, <i>Maid</i> en	Sumame)	un
19a. Informant's Nam O.C.M.E.		ype, Print)					Rural Route Numi		r Town, State, .	Zip Code)
20a. Method of Dispos	Cremation 3	Removal from State	1		(Name of or other place)		Date	20c. Lo	cation - City or	Town, State
21. Signature of Fune	eral Service Licen	in state Wade, Dir	ector	State	e and Address of Anatomy	y Boar	rd 655 W	. Bal	timore	Street
23a. Part 1 Enter the	disease, or comp	olications that caused one cause on each li	the death. Do		more, MI mode of dying, su			arrest,		Approximate Interval Between
Immediate Cau (Fi		Methadone		nol into	xication					Onset and Death
disease or condition resulting in death)	-	a	a consequence		ALCOCION					
			,							
Conventially link and	ditions									
Sequentially list cond	rediale	Due to (or as	a consequence	of):						
if any, leading to immo cause. Enter Underly Cause (Disease or in)	ying 2	b. Due to (or as	a consequence	of):						
if any, leading to immo cause. Enter Underly	ying ijury	c	a consequence							
if any, leading to immo cause. Enter Underly Cause (Disease or in) that initiated events	ying ijury	c								
if any, heading to immocause. Enter Underfy Cause (Disease or injust in the control of the cont	prediate ying girly sixt sixt sixt sixt sixt sixt sixt sixt	c. Due to (or as d	a consequence	of): a 3□Ector	ic pregnancy r (specify)		.535.453		23d. Date of de Month	elivery Day Year
if any, heading to immocause. Enter Underly Cause (Disease or inj that imitated events resulting in death) Last 19	progrant conths?	c. Due to (or as d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	a consequence of pregnancy 2  Fetal death t time of death	of):  3 □ Ector 5 □ Othe	r (specify)	Part I.		I tobacco u	Month use contribute t	Day Year to the cause of death?
if any, heading to immocause. Enter Underly Cause (Disease or injuration of the injure	progrant conths?	c. Due to (or as d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	a consequence of pregnancy 2  Fetal death t time of death	of):  3 □ Ector 5 □ Othe	r (specify)	Part I.		I tobacco u ] Yes 2[	Month use contribute t  No 3 □ P	Day Year to the cause of death?
if any, heading to immocause. Enter Underly Cause (Disease or inj that imitated events resulting in death) Last 19	progrant conths?	c. Due to (or as d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	a consequence of pregnancy 2  Fetal death t time of death	of):  3 □ Ector 5 □ Othe	r (specify)	Part I.	1 24a. Wa	I tobacco u ] Yes 2[	Month use contribute t  No 3 □ P	Day Year to the cause of death? trobably 4 Denknor utopsy findings availal completion of cause of
if any, heading to immocause. Enter Underly Cause (Disease or in) that initiated events resulting in death) Last 19 and	pregnant conditions co	c. Due to (or as d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	a consequence of pregnancy 2  Fetal death t time of death	of):  3 □ Ector 5 □ Othe	r (specify)		1 24a. Wa	I tobacco u  Yes 2[ is an opsy formed? 2 \( \) No	Month use contribute t No 3 P 24b. Were a prior to death?	Day Year to the cause of death? trobably 4 Anknor tutopsy findings availal completion of cause of
Fan, heading to immasses. Enter Underly Cause (Disease or in) that initiated events esulting in death) Last 12 mg. Terminal that initiated events esulting in death) Last 12 mg. Terminal the past 12 mg. 1 □ Yes 2 □ 1 □ Yes 3 □ 1 □ Yes 3 □ 1 □ Yes 3 □ 1 □ Yes 4 □ 1 □ Yes 4 □ 1 □ Yes 5 □ 1 □ Yes 5 □ 1 □ Yes 7 □ 1 □ Yes 7 □ 1 □ Yes 7 □ 1 □ Yes 8 □ 1 □ Yes 9 □ Yes 9 □ 1 □ Yes 9 □ Yes 9 □ 1 □ Yes 9 □	pregnant conditions co	c. Due to (or as d. 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	a consequence of pregnancy 2 Fetal death t time of death out not resulting i	of):  3 □Ectop 5 □ Othe	ng cause given in	. Place of D	24a. Wa aut per 1X Yes	Yes 2[ Is an opsy formed? 2 No	Month use contribute t No 3 P  24b. Were a prior to death?	Day Year  to the cause of death?  robably 4 Anno  uutopsy findings availa completion of cause of
if any, heading to immorause. Enter Underly Cause (Disease or in) that initiated events resulting in death) Last 12 m and 13 m and 14 m and 15 m an	pregnant conditions co	c. Due to (or as d	a consequence of pregnancy 2   Fetal death t time of death out not resulting i	of):  3	ng cause given in  26.  DOA Other: 4	. Place of D	24a. Wa aut per 1X Yes	Yes 2[ is an opsy tormed? 2 No y one) sidence	Month use contribute t No 3 P  24b. Were a prior to death? 1 Ye	Day Year  to the cause of death?  robably 4 Anno  uutopsy findings availa completion of cause of
F FEMALE:  23b. Was decedent p in the past 12 m 1 Yes 2 1 Yes 2 1 N 2 Taxward 12 M 2 M 2 Taxward 1 N 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2 M 2	pregnant conditions of the con	c. Due to (or as d	a consequence of pregnancy 2   Fetal death t time of death out not resulting i	of):  3 □ Ectop 5 □ Othe  n the underly	r (specify)  ng cause given in  26.  DOA Other:  28c. Injury at Work?	. Place of D	24a. Wa aut per 100 (Check only g Home 5 Res	Yes 2[ is an opsy tormed? 2 No y one) sidence	Month use contribute t No 3 P  24b. Were a prior to death? 1 Ye	Day Year  to the cause of death?  robably 4 Anno  uutopsy findings availa completion of cause of
If any, heading to immocause. Enter Underly Cause (Disease or in) that initiated events resulting in death) Last 19 (19 (19 (19 (19 (19 (19 (19 (19 (19	pregnant porting? No cant conditions of the determinant of the determi	Due to (or as d	a consequence of pregnancy 2   Fetal death t time of death out not resulting i	of):  3 Ectop 5 Othe  n the underly  utpatient 3E  Time of Injury 4:00a M	r (specify)  ng cause given in  26.  DOA Other:  28c. Injury at Work?  1 □ Yes	. Place of D	24a. Wa author per per per per per per per per per pe	I tobacco u  Yes 2  Is an opsy formed? 2  No one)  sidence ( 9 how injure)	Month  se contribute to No 3 P  24b. Were a prior to death? 1 Ye  6 Other (Spare)  y occurred	Day Year to the cause of death? trobably 4 Anknor tutopsy findings availal completion of cause of
any, heading to immocause. Enter Underly Cause (Disease or in) that initiated events resulting in death) Last 19 (The Past 12 m 1 9 (The Past 12 m 1 9 (The Past 12 m 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	pregnant conditions control of the conditions condition	Due to (or as d. d. Due to (or as d. d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown ontributing to death be 28a. Date of Injury (Month, Date of Injury) 28e. Place of Injury sician: To the bestniner: On the basis of the council of the page of the	a consequence of pregnancy 2   Fetal death time of death out not resulting i  ent 2   ER/Ot  yy Year) 7006   Fnd iury - At home, fa tic. (Specify) hotel	of):  3 Ector 5 Othe  In the underly  In the underly  4:00a M  arm, street, fa	ng cause given in  26.  DOA Other:  28c. Injury at Work?  1 Yes  ctory, office	Place of C I Nursing No No	24a. Wa auth per 120 Yes Death (Check only g Home 5 Bescribe unk 28f. Location City or T Brooklyn ace, and due to the	I tobacco u  ] Yes 2 [  Is an opsy formed? 2   No v one)  sidence (6 e how injure)  (Street an own, State 1, MD (  e cause(s)	Month  ise contribute to No 3 P  24b. Were a prior to death? iv Ye  6XOther (Sport y occurred)  d Number or F  4900 Ri Park Pla  and manner a	Day Year  To the cause of death?  Trobably 4 Announce of cause of the cause of death?  Trobably 4 Announce of cause of the
If any, heading to immocause. Enter Underly Cause (Disease or in) that initiated events resulting in death) Last 18 and 19 and 1	pregnant properties of the medical loop investigation of the medical loop	Due to (or as  d.  23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown  ontributing to death b  Hospital: 1 Inpatie 28a. Date of Inju (Month, Da 1 Alac of Inju 28e. Place of Inju building, e found in  ysician: To the best	a consequence of pregnancy 2   Fetal death time of death out not resulting i  ent 2   ER/Ot  yy Year) 7006   Fnd iury - At home, fa tic. (Specify) hotel	of):  3 Ector 5 Othe  In the underly  In the underly  4:00a M  arm, street, fa	ng cause given in  26.  DOA Other:  28c. Injury at Work?  1 Yes  ctory, office	Place of C INursing No	24a. Wa auth per 120 Yes Death (Check only g Home 5 Bescribe unk 28f. Location City or T Brooklyn ace, and due to the	I tobacco u  Yes 2  Is an opsy formed? 2 No  Yone) sidence ( Street an own, State  1, MD ( e cause(s) a, date and	Month  ise contribute to No 3 P  24b. Were a prior to death? iv Ye  6XOther (Sport y occurred)  d Number or F  4900 Ri Park Pla  and manner a	Day Year  To the cause of death?  Trobably 4 Anno  Trobab
If any, heading to immocause. Enter Underly Cause (Disease or in) that initiated events resulting in death) Last 18 and 19 and 1	pregnant program to the program to t	Due to (or as d. d. Due to (or as d. d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown ontributing to death be 28a. Date of Injury (Month, Date of Injury) 28e. Place of Injury sician: To the bestniner: On the basis of the council of the page of the	a consequence of pregnancy 2   Fetal death time of death out not resulting i  ent 2   ER/Ot  yy Year) 7006   Fnd iury - At home, fa tic. (Specify) hotel	of):  3 Ector 5 Othe  In the underly  In the underly  4:00a M  arm, street, fa	g cause given in  26.  DOA Other:  28c. Injury at Work?  1 □ Yes  ctory, office	Place of C INursing No	24a. Wa auth per 120 Yes Death (Check only g Home 5 Bescribe unk 28f. Location City or T Brooklyn ace, and due to the	I tobacco u  ] Yes 2 [  is an opsy formed? 2   No v one)  sidence (6 a how injure)  (Street an own, State 1, MD (  e cause(s) a, date and 29d. Dat	Month  Ise contribute to the second of the s	Day Year  To the cause of death?  Tobably 4 Anknor  Total Route Number,  Total Route Number,  Total Highwa  Tax Hotel  To the cause(s)
F FEMALE:  23b. Was decedent p in the past 12 m 1   Yes 2   N 2   Unknown  2at II. Other significat 1   Natural 2   Accident 3   Suicide 4   Homicide  29a. Certifier (Check only 2 one)  29b. Signature and tit	oregnant nonths? No  cant conditions or determined  Description of the conditions of the conditions or determined  Could not be determined  Could not be determined  Could not be determined  Could not be determined	Due to (or as d. d. 23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown ontributing to death be 28a. Date of Injury (Month, Date of Injury) 28e. Place of Injury in the basis of and manner stocompleted cause of completed cause of a second cause of completed cause of a second ca	a consequence of pregnancy 2   Fetal death t time of death out not resulting i  ent 2   ER/Ot lay y Year) Thomas fic. (Specify) hotel of my knowledg of examination ar alted.	of):  1 3 Ector 5 Othe  1 the underly  1 the underly  2 the underly  4 the underl	26. License nu	Place of C I Nursing No No late and plate, death oc	24a. Wa auth per 120 Yes Death (Check only g Home 5 Bescribe unk 28f. Location City or T Brooklyn ace, and due to the	I tobacco u  Yes 2  Is an opsy formed? 2 No or one)  sidence ( Street an own, State 1, MD ( e cause(s) e, date and  29d. Dat  Narco	Month  Isse contribute to the second of the	Day Year  To the cause of death?  Tobably 4 Ankno  Total Route Number,  Total Route Number,  Total Highwa  Taxa Hotel  To the cause(s)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2000 1341 Gilbert DALJANI 07 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Howard Howard County General Hospita Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) 02/04/1944 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1**∑**M 2□F 216-37-1718 Albania Director Usual Residence of Decedent permit. Pages 1 end 2 should be tiled within 72 hours attar death with the Maryland Department of Health and Mental Hygiane. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow any njury or other treumalic event, the Madical Eventral. 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Elkridge 1 Yes 2 No MD Howard **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21075 6620 Washington Blvd. HSA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: White δ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Strasburger & Siegel, INC. Efementary/Secondary (0-12) Coflege (1-4or 5+) 5+ Chemist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Terezina Volai Adam Dajlani 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6556 Elderberry Ct., Elkridge, MD 21075 Patris Xega / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mamorial Park, INC 04/09/06 Elkridge, MD Gary L. Kaufman Funeral Home at, MMP, INC. 7250 Washington Blvd., Elkridge, MD 21075 21. Signature Funeral Service Lice M01378 inplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. 23. Part1. Enter the disease, of and shock, or heart failure. List only Approximate Interval Between Onset and Death ediate Cause (Final encephalopathy **Physician** Anoxic days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cardio pulmonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that but had been caused.) Examiner anding physicien and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Yeavs Coronary that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Be Completed by Physician/Medical signed by the attending be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 25. Was case referred to medical examiner? 26. Pface of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes \_2 ₩0 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28 a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. tnjury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Maturaf 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A completely tilled in by the fu investigation 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide t 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 142892 07 2006 udian -MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10724 Little Patux-ent Francis Columbia 21044 Chuidian Parkway

State

Registrar

31. Date filed (Month, Day, Year)

APR 1

32. Registar's Signature

2006

			<b>1</b> _ s	For State	State of Marylan				Mental Hyg	iene 0 0 6	
			В	Registrar cedent's Name (First, Middle, Las	st)		ertificate	or Death	2. Date of Deal	eg. No.	3. Time of Death
	Physici		1. 000	K 1 - T 11 1 5-	- N/ 5		DA	MIEI	Month	Day Year 5 200	
	/Medic Examir		4a. Fa	acility Name (If not institution, give	e street and number)	/	4b. City, Toy	vn, or Location of Dea	th	4c. County of De	0 1.
	CXAIIIII	ici	4	1		ITAL	12	ALTIMOR		N/	A
	Funeral		5. Soc	cial Security Number 6. S	ex 7. Age (In yrs.		y) If Under 1 Y Months D		8. Date of Birth	Year) 9. B	rthplace (State or Foreign
1	Director		21	9-20-0295	□M 2 <b>/S</b> .F	Yrs.	Mortins	ays Hours Will	MARCHO		RTH CAROLINA
	and w		Usual 10a. S	Residence of Decedent State 10b. County	10c. Cit	y, Town or	Location			,	10d. Inside City Limits
	Aaryk Febo	5	A/A	RIVAID AL	12	,,,	B	ALTIMO	DOE C	, 71	1)SYes 2 □ No
	28a-	Director	/7/17 10e. S	Street and Number	177		10f. Zip Co			0g. Cilizen of What 0	Country?
	3a or		4	112 FAST	JOND STRE	FT		2121	18	451	,
	death me 2	Funeral	11. Ma	arital Status	12. Was Decedent Ever in U	.S. 13	3. Was Deceden	of Hispanic Origin? (	Specify Yes or No-	14. Race - Arr	erican Indian,
39	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other then "naturel", or iteme 23a or 28a-f ehow or other treumatic event, the Modical Exartinal for Extilling at		1	Never Married 2  Married   □ Widowed 4  □ Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀	Cuban, Mexican, Puè No <i>Specify:</i>	no Rican, etc.)	Black, Wh	Ite, etc.
5-0036	2 hou	Completed by		15. Decedent's Ec	ducation	16a. De	edent's Usual C	ccupation lone during most of wo	-4:	16b. Kind of Busines	s/Industry
215	within 7 ene. then "r	nple	Ejer	mentary/Secondary (0-12)	College (1-4or 5+)	life	. DO NOT use r	etired)	orking	,	
2121	filled wi Hygien Ither th	ပ်	9	+HGRADE		4	TUNDI		KER		ROMAT
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, ITE M	Be	17. Fa	ather's Name (First, Middle, Last)	_	. 1 10-	,	/ 18. Mother's Na	me (First, Middle, I	Maiden Sumame)	/
2	should nd Men marke imaric	2	1	DEWEY Informant's Name/Relationship (		NIE		treet and Number or R		ALS	100
Z	d 2 sl th an th an treur treur		D.	niomants Name/Aelationship (	115 (SISTER)	190. Ma	A A A A	-	AVE. APT. 1	city of rown, state,	THE THE
ė	1 and 1 Health tem 27		20a. N	Method of Disposition	20b. F	Place of Dis	position (Name	of .	7	20c. Location - City of	r Town, State
2	Peges nent of i int: if it			Burial 2 Cremation 3 Donation 5 Other (Specification)	Hemoval from State		ematory or othe	à 1	12-01	Barrin	or UN
Baltimore,			-	ignature of Funeral Service Licer			22. Name and A	ddress of Facility	12 00	OHEIMO	RE, MD.
B	permit. Depertrimports eny inju			i aqual	N. Willian	2	J9435	PHHA	AVE BA	ALTO MD.	21217
			23a.	Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not e	inter the mode o				Approximate Interval Between
1	Physician		disea	ediate Cause (Final	MUNCO	rdia	$\lambda$	Infar	ction	1	Onset and Death
4	/Medical Examiner		result	ting in death)	Due to for as a conseq	uence of):					
	LAdimine	_	Seque	entially list conditions,	b	Arese and					
	ted sit	niner	cause Cause	e. Enter Underlying  e (Disease or injury	Due to (ci as a conseq	lagina ori.					
	axecu al-tra	Examin	that in	nitiated events ling in death) Last	c. Due to (or as a conseq	juence of):					
68760,	ficate be executed g physicien and as the burial-transit	edicail			d						
		led									
Вох	eath certif attending for use a	an/N	23b. \	MALE: Was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		B⊟Ectopic pregr	ancy		23d. Date of d	
	the att	Physician/M	1	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d		Other (special			Month	Day Year
P.0	thet the de ed by the detached	Phy		9 ☐ Unknown  Other significant conditions of		udtion in the		o aven in Best I	220 Did to	hagan uga gantributa	to the cause of death?
of Vital Records,	sign a pe	ed by	rai(11.	. Other significant conditions of	contributing to death but not res	in the	underlying caus	e given in Part I.			Probably 4 DUnknown
ဝ	e law requ hes been je 2 shouk	Completed							24a. Was a autops	n 24b. Were	autopsy findings available completion of cause of
<u> </u>	The l	EOC							perform	med2/   death?	s 2 No
/ita	ysician: Th is certificate director, pag	Be (	25. W	/as case referred to medical kaminer?		,			eath (Check only on	18)	
5	hysi this c	မ		☐ Yes 2 17 No		ER/Outpat				ence 6 □Other (Sp	ecify)
	ding Ph h. After th funeral	lon	1.0	anger of Death ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injur	of 28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe ho	ow injury occurred	
Division	death death ctor: y the	licat	3	☐ Accident investigation ☐ Suicide 6 ☐ Could not b	ODe Pleas of Initial At h	ome farm			28f. Location (Si	treet and Number or I	Rural Route Number
Θ	s effer i Dire	Certification:	4	☐ Homicide determined	building, etc. (Specil	(y)	,,		City or Town	n, State)	
١	To the Hospital or Attending Physician: within 24 hours effer death. To the Funerei Director: Affer this certifica completely filled in by the funeral director,	Medical (		Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, de ation and/or	ath occurred at t investigation, in	he time, date and place my opinion, death occ	e, and due to the coursed at the time, d	ause(s) and manner ate and place, and di	as stated. ue to the cause(s)
/	To th withir To th comp	Me	29b. S	Signature and title of certifier			29c. L	cense number	2	9d. Date signed (Mor	
				X	Jun 5		N	14926	59	04/05	106 Himore, MD
			30. Na	ame and address of person who	completed cause of death (Iter	n 23a) (Typ	e, Print)	. 1	11	1 0	1. 000
				miel Tekl	dy, mD (		o When	norial	Worbit	al Ba	Himore, I'll
	Sta Registr		31. Da	ate filed (Month, Day, Year)	32 Registrar's Signa	ature	ack		1		,

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene and

	1 - For State Registrar		rtificate of Death	Reg. No.	000 11013
Physician /Medical	Decedent's Name (First, Middle, Last)     Joseph Antho			2. Date of Death Month Day April 3 20	
Examiner	4a. Facility Name (If not institution, give GREATER BALTIMORE		4b. City, Town, or Location of Death TOWSON	4c.	County of Death ALTIMORE
Funeral Director	5. Social Security Number 6. Sec 219-18-4710	7. Age (In yrs. last birthday, 83 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Year) 10/31/1	9. Birthplace (State or Foreign Country) 1922 Maryland
and	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
the Marylar 286-1 show notified at	Maryland N/A	Ba1	timore		1∭Yes 2☐No
of the death with the Mar in terms 23a or 28e-1 sincer must be notified funeral Director	10e. Street and Number 6606 Harford Road		10f. Zip Code 21214		izen of What Country? United States
J & 5 5 9 9	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4√□ Divorced	12. Was Decedent Ever in U.S. Armed Forces? WWIII IYYes, 2 □ No WIII IYYes, Give Year or Dates: Korea	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican Puerto  1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
21215-00 ed within 72 hou ygjene. Per than "nature t, tre Maller!	15. Decedent's Edu (Specify only highest grad	College (1-4or 5+) (Given life.	dent's Usual Occupation e kind of work done during most of work DO NOT use retired)	king	nd of Business/Industry
d 2121 d 2121 filed within Hygiene. vther than " ant, tre M.	Elementary/Secondary (0-12) 12th Grade  17. Father's Name (First, Middle, Last)	College (1-4or 5+) 2Years Airp	olane Mechanic	ne (First, Middle, Maiden	S. Airforce
aryland should be fill not when at it marked out umatic even	Joseph Nicholas E	DePetris		Marchioni	Sumanne)
1 40 01 00 20 20	19a. Informant's Name/Relationship (Ty Paul DePetris- Son		ing Address (Street and Number or Ru.  D Evergreen Avenue		r Town, State, Zip Code)
	20a. Method of Disposition  1 ☑ Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	20b. Place of Disp cemetery, cre Garrison	matory or other place)		ngs Mills, MD
Baltimor permit. Pages Department of Importent: If ite any injury or of once.	21. Signature of Fine All Ambe Licens	<sup>∞</sup> Charles Miner <sup>2</sup>	2. Name and Address of Facility	5305 Ha	rford Road
	23a. Part 1. Enter the disease, or compl shock, or heart failure. (List/only o	ications that caused the death. Do not er			Approximate Interval Between
Physician /Medical	Immediate Cause (Final disease or condition resulting in death)		Respiratory Fail	we	Onset and Death HHOVS
Examiner	Sequentially list conditions.	)			
executed in and ital-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):			
	that initiated events resulting in death) Last	Due to (or as a consequence of):	· · · · · · · · · · · · · · · · · · ·		
687 tiflicate g phy as the		J			
Box ath ce attendi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
is, P.O. less that the de igned by the able detached by by by by by Physic		ntributing to death but not resulting in the	underlying cause given in Part I.		use contribute to the cause of death?
cord  requir  been si should leted					□ No 3 □ Probably 4 ☑ Unknown
Division of Vital Records, or attending Physicien: The law requires the death. Director: After this certificate has been signed in by the funeral director, page 2 should be certification; To Be Completed by				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
on of Vital F ding Physicien: Th h. After this certificate funeral director, pag tlon; To Be Coi	25. Was case referred to medical examiner?	Hospital:	Other	th (Check only one)	
of N Physi or this c eral dir	27. Manner of Death	28a. Date of Injury 28b. Time	SIL SU DOA 4 1 INDISHIGH	ome 5 Residence 28d. Describe how injur	
ision ttending death. ctor: Afte y the fun	1 Natural 5 Pending investigation	(Month, Day Year) Injury	Work?  M 1 ☐ Yes 2 ☐ No		
Division c tel or Attending P rs after death. al Director: Alter I ed in by the funers Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Street an City or Town, State	nd Number or Rural Route Number, s)
DIVI To the Hospitel or At within 24 hours after C To the Funeral Direct completely filled in by Medical Certiff		sician: To the best of my knowledge, dea ner: On the basis of examination and/or i and manner stated.			
Toth within Toth comp	29b. Signature and title of certifier	1 no	29c. License number		te signed (Month, Day, Year)
104)	30. Name and address of person who co	completed cause of death (Item 23a) (Type 6565 N Charles		So Him	nore mazizo4
State	31. Date filed (Month, Day, Year)	32. Registrar's Signature			· .
Registrar	APR 1 0 2006	32. Registral 5 Signature			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 8, 2006 Year **Physician** Catherine Ann Dietrich 11:40 am /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Towson Baltimore 5. Social Security Number 220-56-9401 9. Birthplace (State or Foreign Mary) and 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth June 14, Year 951 **Funeral** 1□M 2XF 54 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location r 28a-f ehow 1 ☐ Yes 2 No Baltimore Baltimore Md. Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 end 2 should be filed within 72 hours after deeth with Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural; or items 23a or early injury or other traumatic event, in a Medical Examinal must be once. 21212 271 Stanmore Rd. USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (134or 5+) Registered Nurse Nursing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Posko, Sr. Theresa Dypsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. John H. Dietrich/ Son 271 Stanmore Rd. Baltimore, Md. 21212 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Dulaney Valley Mem. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4-12-06 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Nameand Address of Facility</sup> Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition Physician EncephalopuThy Weeks ANUXIZ /Medical resulting in death) Due to (or as a consequence of) Examiner weeks yo(ardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ettending physicien and for use as the burial-transit Due to (or as a consequence of) .O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 Yes 2 No 3 Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 is autopsy performed? 1 Yes 2 No 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one 2 Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Dether (Specify) Jas/11 Ce 1 Yes 2 70 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospital 12 Cartifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier April, 9, 2009 D0061199 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Black Touson MO 21204 660I St. North Charles 31. Date filed (Month, Day, Year) APR 1 0 2006 32 Registrar's Signature State (soule) Registrar

**ORIGINAL** 

II. YOAM

t

April B, acole

			1 - For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H		Mental Hy	/giene	16	1017
			Decedent's Name (First, Middle, La.	st)				2. Date of De			3. Time of Death
	Physici	an	Evelyn J. Ene					Month	Day L 2	Year	7:58 P M
	/Medic		4a. Facility Name (If not institution, give			4h City Town o	or Location of Deat	April		2006 nty of Death	
4	Examin	ıer								,	
			St. Agnes Hos		e (In yrs. last birthday)		imore If Under 24 Hrs	8. Date of Bi		1/a	place (State or Foreign
	Funeral Director		1	□M 2ME	72 Yrs.	Months Days	Hours Min.	(Month, D	ay, Year)	Cou	intry)
Ь.	Director		224-44-4496 Usual Residence of Decedent		2		1	June 2	4, 1933	Viro	ппа
	land bw		10a. State 10b. County		10c. City, Town or Le	ocation			-		10d. Inside City Limits
	Many f sh	ō	Maryland n/a		Baltimo	ro					11∏ Yes 2 ☐ No
	the 28a	ect	10e. Street and Number		Darchik	10f. Zip Code			10g. Citizen o	of What Cou	intn/2
	with	ă	435 Yale Avenue			21229	0				into y :
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show the Madigal Examither mat be mattled at	<b>Funeral Director</b>		12. Was Decedent	Ever in II C 12			Sporify Voc or N		JSA ace - Amer	ioan Indian
	er de Item	n	11. Marital Status	Armed Forces?	EVEL IN U.S. 13.	Was Decedent of H If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)	0- 14. N	lack, White	
36	rs aff	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 <b>X</b> If If Yes, Give Year or Dates:	10	1 ☐ Yes 2 🎇 No	Specify:		Spec	city: W	hite
21215-0036	hour tural	be	15. Decedent's Ed		162 Doco	dent's Usual Occur	nation		10h Kind of	Dusings //	
5	n 72	Completed	(Specify only highest gra		(Give	kind of work done DO NOT use retire	during most of wo	rking	16b. Kind of	Dusinessyll	idustry
12	withi ane. than	m	Elementary/Secondary (0-12)	College (1-4or 5	Homen		-,		Orm I	Tomo	
2	filed with Hygiene kther thai		11 17. Father's Name (First, Middle, Last)	0	nomen	arer	18 Mother's Na	me (First, Middle	Own H		
ä	Mental Parked of arked of atic ever	Be	Samuel Wood							ame)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deparmient of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinet must be notified at once.	To	19a. Informant's Name/Relationship (	Torre Drive	405 14:28			V. Cooke			
Vai	12 sho					ng Address (Street					· · · · · · · · · · · · · · · · · · ·
	1 and 3 Health em 27 ther tra		Carolyn P. Watt	- daugnter	20b. Place of Dispo	Shetland	square,	Date Bu	1		
Baltimore,	Pages 1 nent of H int: if Ite		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State	cemetery, cre	matory or other pla	ce)	Date	20c. Location	n - City or I	own, State
Ξ.	permit. Pag Department Important: I any injury o		`4 ☐ Donation 5 ☐ Other (Specif		Bayview (						Maryland
alt	permit. Departn Imports any inju		21. Signature of Funeral Service Licer	isee	2	2. Name and Addre	ess of Facility Hu	ıbbard F	uneral	Home,	Inc.
m	89 = 9		1 Sichael	Jano							and 21229
	Y.		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. Do not en						Approximate Interval Between
	Physician		Immediate Cause (Final	SEPTIC S							Onset and Death 2 Weeks
	/Medical		disease or condition resulting in death)	a	a consequence of):						2 HOURD
	Examiner				ITONEAL HE	MMORHAGE					2 Weeks
	the house	er	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a consequence of):						
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	ATRIAL F	'IBRILLATIC	N WITH A	NTIGOAGUI	LATION T	REATMEN	IT	1 Year
,	al-tra	Exa	resulting in death) Last	Due to (or as	a consequence of):						
8760,	cate be executed physician and the burial-transit	dical	· ·	d							
89	ficate phy s the	edic		u							
×	death certific attending p	W/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy				23d [	Date of deliv	re rv
Вох	attel for (	ciar	in the past 12 months?	1□Live birth 4□Pregnant at		□Ectopic pregnancy □ Other (specify) _	у			<b>Jonth</b>	Day Year
o.	the the	Physician/Me	1  Yes 2 No 9  Unknown	9□ Unknown							
Δ.	res that the signed by be detact		Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	Inderlying cause giv	ven in Part I.	23e. Did	tobacco use co	ntribute to	the cause of death?
ds,	sign sign d be	d by	Hemorrhagic					10	Yes 2 No	3 ∏ Pro	bably 4 \to Unknown
Ö	w requir been si should	ete									
Vital Records,	has has	Completed	Rheumatoid	AI LIII I LIS,	on Methot	lexace		24a. Was			opsy findings available ompletion of cause of
F		S						1X Yes	2□ No	Yes	2 🗆 No
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					ath (Check only	one)		
of \	S 0 = D	P	1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ER/Outpatie	nt 3□ DOA Ott	ner: 4 🗆 Nursing H	Home 5 ☐ Res	idence 6 🗆 C	ther (Speci	fy)
	ding Phy h. After thi funeral	ü.	27. Manner of Death  ↑ Natural 5 ☐ Pending	28a. ate of Inju (Month, Da	ry 28b. Time o y Year) Injury	of 28c. Injus Woo	ry at rk?	28d. Describe	how injury occ	urred	
Sio	endi sath. or: A he fu	ati	2 Accident investigation			M 1 🗆	Yes 2 □ No				
Division	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Inj building, et	ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location ( City or To	(Street and Nur own, State)	nber or Rur	al Route Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	Ce									
	hou uner uner	edical	29a. Certifier Certifying Ph	ysicien: To the best	of my knowledge, deat f examination and/or in	th occurred at the til	me, date and place	e, and due to the	cause(s) and	manner as	stated.
	he H in 24 he F plete	edi	one)	and manner sta	ated.		opinion, death occi	aned at the thine,	, date and place	s, and due i	O the cause(s)
	To t To t Com	Σ	29b. Signature and title of certifier			29c. Licens	se number		29d. Date sign	ned (Month,	Day, Year)
•			1 vaic	- any		D52	2540		Ap	ril 3	, 2006
			30. Name and address of person who	completed cause of d	leath (Item 23a) (Type,	Print)					
			Thomas J. Enelo				00 Caton	Avenue	Baltim	ore, 1	4D 21229
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regis	ar's Signature	don't .					
lt	Registr	ar	APR 1 0	2006	March A.	A STATE OF THE PARTY OF THE PAR					

ENEY, EVELYN J.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death FORNOFF 0245 2006 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death COLUMBIA HOWARD COUNTY GENERAL HOSPITAL Howard If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Hours 1₩ 2□F 217-30-3247 April 29, 1935 Maryland Usual Residence of Decedent 10c. City, Town or Location 10h County 10d. tnside City Limits 1 Yes 2 No Maryland Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 100 Andrews St 21643 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Btack, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 ₩Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cotlege (1-4or 5+) 4 Laborer Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George I. Fornoff. Margaret E. Fogarty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Barlow- Daughter 1808 Jackson St, Baltimore, mD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Meadowridge Memorial Park 4/8/2006 Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, INC. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 200. 100 per part of the province Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death)

Examiner as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, s been signer should be d nerel Director: A filled in by the fi within 24 hours after d To the Funeral Direct completely filled in by

**Physician** 

/Medical

10a State

Examiner

**Funeral** 

Director

rei', or iteme 23a or 28e-f ehow Examiner must be notified at

"naturei",

f Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Madical

permit. Pages 1
Department of H
Important: If ite
any injury or ot
once.

**Physician** /Medical Directo

by Funeral

Completed

Be

with the Maryland

death v

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

4+1

	Sequentially list conditions.	VANCOMYCIN	RESISTAN	T ENTEROCOCC	WS SEPS	is	DAYS
amine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	RENAL	DISEASE			DAYS
dical Ex	d.	Due to (or as a consec HYPOGLY (	. ,				DAYS
Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	Sc. If yes, outcome of pregn.  1 Live birth 2 Feta 4 Pregnant at time of o	al death 3 □Ectopio	c pregnancy (specify)		23d. Date of de Month	elivery Day Year
ed by Pt	JOCO DITTO CA	CERS	sutting in the underlyin	ng cause given in Part I.	23e. Did tobacc	/	to the cause of death?
Complet	GANGRENE OF		SEASE_ ET		24a. Was an autopsy performed 1 Yes 2	death?	utopsy findings available completion of cause of
Be (	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one)		
	1 ☐ Yes 2 No	ospital: 1 npatient 2	ER/Outpatient 3□	DOA Other: 4 Nursing H	ome 5 Residence	6 ☐Other (Spe	ecify)
ation;	27. Manner of Death 11☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	tury occurred	
Medical Certification; To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	iome, farm, street, fac	tory, office	28f. Location (Street City or Town, Sta	and Number or F ate)	tural Route Number,
<u>e</u>	29a. Certifier 12 Cartifying Phys	ician: To the best of my kno	owledge, death occurr	red at the time, date and place tion, in my opinion, death occu	, and due to the cause	(s) and manner a	s stated.
edic	(Check only 2 Medical Examin one)	and manner stated.	attori aria or irrestigar	,,,		ina piaco, ana aa	e to the cause(s)
Medic	(Check only 2 Medical Examin	and manner stated.		29c. License number		Date signed (Mon	171

DHMH 17 Rev 1/2001

State Registrar 5155 CEDAR LANE, COLUMBIA, MD

30. Name and a drest of person who completed cause of death (Item 23a) (Type, Print)

32. Registras Signature

HETA-CAT JACKSON 600TH

31. Date filed (Month, Day, Year)

		- For Amend Items# 16	a&b per	FH G854 471	2/06 CC	Death	nemai riyu	leg. No.		1013		
Physicia /Medic	ın	Decedent's Name (First, Middle, Last)	Bever	ly Ann Fog	38		2. Date of Dea Month 4		0 <sup>Year</sup>	3. Time of Dear 10:30 a		
Examine	_	4a. Facility Name (If not institution, give s 3331 Fieldview Ro			4b. City, Town, or Woodlawn	Location of Death		4c. County Balto				
Funeral Director		217 30 3030	M 2 F 7. Ag	e (In yrs. last birthday) 54 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	r, Year)	9. Birthpla Count	ace (State or For ry) Va		
land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation		2		10	d. Inside City Lin		
r 28a-1 show	tor	Md Ba:	lto	Woodla	wn					1 ☐ Yes 2 🛱		
or 28a	irec	10e. Street and Number		1	10f. Zip Code			10g. Citizen of V	Vhat Count	ry?		
23£ 0	raic	3331 Fieldview Roa	ad		21207	7		USA				
urs a	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No I	Was Decedent of H f Yes, specify Cuba l □ Yes 2 ☑ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blac	e - America k, White, e Block	itc.		
natural;	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occupa	during most of work	tina	16b. Kind of Bu				
⊆ _ 3	mpie	Elementary/Secondary (0-12)	College (1-4or 5	(ite. (	DO NOT use retired	<b>Preside</b> n		Morgan :	State	Univers		
e filed with Il Hygiene. othar thar /ent, the N		12th grade  17. Father's Name (First, Middle, Last)	4 yea	rs	ant vice	18. Mother's Name		Maiden Sumam	(A)			
	To Be	Robert A. Jackson				Ann Dusc		maioon odinani	,			
d 2 should be th and Mental 7 Is markad of traumatic ev	-	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailir	g Address (Street	and Number or Run		r, City or Town,	State, Zip	Code)		
252		Percy Fogg - Husba	and	3331	Fieldvie	w Road	Woodlaw	m, Md 2	1207			
2 = 2		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ R	emoval from State	20b. Place of Dispo	sition (Name of natory or other plac	(8)	Date	20c. Location -	City or Tov	wn, State		
nii. Pages vartment of l ortant: If its injury or o		`4 ☐ Donation 5 ☐ Other (Specify)		Woodlawn				Balto C	o, Ma	l		
permit. Page Department of Important: If any injury or once.		21. Signalure of Funeral Service License	Keke	- 1	4300 W	<sup>ss of Facility</sup> Mar abash Ave	enue Ba	lto,Md	21215			
		23a. Parl 1. Enter the disease, or compli- shock, or hear failure. List only on	cations that caused e cause on each li	d the death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arr	rest,		Approximate Interval Between Onset and Death		
hysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. LNA 8 for overce Concer  Due to (or as a consequence of):  Hiphrephois from Force Concer  Sequentially list conditions,										
Examiner			Due to (or as	a consequence of):	no ta	me Nove	aren Co	ne				
** ** **:	er	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence of):	ν	0						
outed ad ransit	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											
icate be executed physician and sthe burial-transit	EX											
cate be executed physician and the burial-transit	edicai											
70.65		IF FEMALE:	3c. If yes, outcome	of preopenty	<del></del>							
death certii e attending id for use a	Physician/M	in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dat	e of deliver nth	ry Day Year		
by the tached	ysi	1 □ Yes 2.☑ No 9 □ Unknown	9□ Unknown									
	by P	Part II. Other significant conditions con	tributing to death b	ut not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use con	ribute to the	e cause of death		
been sig							1 🗆 Y	es 20 No	3 🗌 Proba	ably 4 Unkno		
has been be 2 shoul	Completed						24a. Was a	an / 24b. \	Nere autop	sy findings availa		
	E OC						perfor	med/7	death?			
certificate rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of Deat	h (Check anly or	10)				
hy shis shigh	2	1 ☐ Yes 2 ☑ No ☐ H	ospital: 1 ☐ Inpatie 28a. Date of Inju			4   Nursing Ho	ome 5 Resid			)		
utter death. Director: After in by the funer	tion	1 Natural 5 Pending	(Month, Da	y Year) 285. 11me of Injury	Worl	yat k? Yes 2 □ No	28d. Describe h	ow injury occurr	ea			
after death. Director: A	Certification:	3 Suicide 6 Could not be	28e. Place of Ini	ury - At home, farm, str		103 2 110	28f. Location (S	treet and Numb	er or Rural	Route Number.		
after Direction by	erti	4 Homicide	building, et	c. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or Tow	n, State)				
	edical C	29a. Certifier 1 Certifying Phys	ician: To the best er: On the basis o and manner st	of my knowledge, death f examination and/or in ated.	n occurred at the time vestigation, in my of	ne, date and place, pinion, death occur	and due to the o	cause(s) and ma date and place, a	nner as sta and due to	ated. the cause(s)		
within To th comp	Me	29b. Signature and title of certifier	11		29c. License	e number	2	29d. Date signed	(Month, E	Day, Year)		
1		*X Las	Man	_	D	38970	2	4/7/	06			
D		30. Name and address of person who co	mpleted cause of c	death (Item 23a) (Type, Of School ar's Signature	Print)			1				
		Found Abbes	2411 603	est Belvea	les Ave,	MOS206.	bolto 1	14/2/2,	15			
* - Stat	te	31. Date filed (Month, Day, Year)  APR 1 0 200	32 Registr	ar's Signature	all s							

			For State Registrar	State of I	Maryland	-	artment of	Health and I		iene	06	1020		
			Decedent's Name (First, Middle, )	Last)					2. Date of Deat	th	V	3. Time of Death		
	Physici /Medi		Oscar Armondo	Fasce					April 7	7, 2000	5 Year	11:53p M		
	Examir		4a. Facility Name (If not institution, g	give street and number	er)		4b. City, Town,	or Location of Death	h	4c. Cour	ity of Deat			
			Gilchrist Hospi				Towson				Balti	more		
	Funeral		,	. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. I		If Under 1 Year Months Days		(Month, Day,	Year)	9. Birt	hplace (State or Foreign nuntry)		
	Director		212–48–2339 Usual Residence of Decedent	'A''' E''.	/	O Yrs.			Oct.18,	1935		entina		
	land		10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits		
	ith the Marylar or 28a-f ehow	ō	Maryland Baltin	nore		Т	imonium					1 ☐ Yes 2 ☑ No		
	the 28a	Jec.	10e. Street and Number				10f. Zip Code		1	0g. Citizen o	f What Co			
	th with 23a or		12320 Rosslare F	Ridae Road	. #208		21093			United				
	filed within 72 hours after death with the Maryland Hygiene. Hygiene. Then "naturel", or Items 23s or 28s-f ehow ent, tre Medical Examinat must be multified at	Funeral Director	11. Marital Slatus	12. Was Decede	nt Ever in U.S			Hispanic Origin? (S ban, Mexican, Puert		14. R	ace - Ame	ncan Indian,		
9	after or Ita	큔	1 Never Married 2 Married	Armed Force 1 1 Yes 2 (		i i			o Hican, etc.)	В	lack, Whit	e, etc.		
93	ours	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Date	s:		☐ Yes 2√2 No	o Specify:		Spec	<sup>⊮y:</sup> Wh	ite		
5-	72 hours "naturel",	Completed	15. Decedent's (Specify only highest)	Education grade completed)		16a. Deced	lent's Usual Occu	upation e during most of wor red)	rking	16b. Kind of	Business/	Industry		
2	vithin Den.	d d	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life. I	OO NOT use retir	red)						
2	iled v dygie ther t	ပိ	17. Father's Name (First, Middle, La	4		Ba	rber	10 Mother's No.	/Circh Middle /	Self		oyed		
and	od of	Be							ne (First, Middle, I	walden Sumi	ame)			
2	should ind Men marke	2	Armondo A. Fas  19a. Informant's Name/Relationship			10h Mailia	- Add (Char		A. Gonz			7-0-1		
Maryland 21215-0036	d 2 s th an 7 le r treur							et and Number or Ru						
	es 1 end 2 of Health a of Item 27 le		Sylvia R. Fasce 20a. Method of Disposition	, wile	20b. PI		ROSSIAT sition (Name of	re Ridge F		Timor 20c. Location				
5	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3	☐Removal from Sta	ite Ce	metery, cren	natory or other pla	ì						
Baltimore.	permit. Pages 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Information the street if Item 27 is marked other than "naturel eny injury or other treumatic event, It a Madical Expanse.		4 Donation 5 Other (Spe 21. Signature of Fundal Service Un		it Dular			al Coms. 4/1		limonium	, Mar	yland Services of		
B	Dep de la perior dela perior de la perior dela perio		· WITH AST		MO1	i		ley, P.A. 2						
			23a. Part1. Enter the disease, or co	emplications that caus						<del></del>	шши	Approximate		
	Obveision		shock, or heart failure. List only one cause on each line.  mmediate Cause (Final											
	Physician /Medical		disease or condition resulting in death)		astati as a consequ		state (	uncer				years		
	Examiner			Due to (or	as a consequ	erice oi).								
(4)		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequ	ence of):								
13	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
3	te be executed ysicien and e burial-transit	Exa	resulting in death) Last	Due to (or	as a consequ	ence of):								
2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	sate be executed hysicien and the burial-transit	cai		d										
98	ntlfica ng ph		IS ECALAL C.											
S S	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor 1 ☐ Live birth	me of pregnar		Ectopic pregnanc	cv			ate of del			
	ed fo	SICI	in the past 12 months? 1 ☐ Yes 2 ☐ No		at time of de		Other (specify)			, A	Aonth	Day Year		
) O. A	at the	Phy	9 Unknown											
7 0	The law requires that the site has been signed by the bage 2 should be detache	þ	Part II. Other significant conditions	s contributing to death	h but not resu	lting in the ur	iderlying cause g	iven in Part I.				the cause of death?		
oro	sen s	ted							1 □ Ye	s 2 No	3 □ Pr	obably 4 Hnknown		
	law nasb	nple							24a. Was an autops	V	prior to d	topsy findings available completion of cause of		
THE H	The page	Completed							perform 1 ☐ Yes 2	ned?	death?	2 No		
) /ita	clan: ertific	Be	25. Was case referred to medical examiner?						ith (Check only on					
0, 5	Physician: this certifica ral director, p	မ	1 ☐ Yes 2 ♣ No		atient 2 E		3□ DOA O	ther: 4 Nursing H				ON Hospice		
SCE, OSCAR L Division of Vital Records	ling F	Certification;	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of II (Month, I	njury Day Year)	28b. Time of Injury	28c. Inju		28d. Describe ho	w injury occi	urred			
177 58	ttending death. tor: Afte	cat	2 Accident investigat 3 Suicide 6 Could not	be co- Di	Alba			]Yes 2 □No	006 Lanating (0)					
S	or A after Direct in by	rtf	4 ☐ Homicide determine	ed 286. Place of building,	etc. (Specify,	me, rarm, stre	et, factory, office	•	City or Town	reet and Nun i, State)	nber or Hu	ral Route Number,		
4	Hospital	Ö	29a, Certifier 1 Certifying	Physician: To the be	ust of must know	uladea dash			and due to the co					
T	24 hg 24 hg Fun etely	Medical	(Check only 2 Medical Ex	aminar: On the basis and manner	s of examinati	ion and/or inv	estigation, in my	opinion, death occu	rred at the lime, da	iuse(s) and rate and place	nanner as e, and due	to the cause(s)		
1	To the within 2 To the comple	Me	29b. Signature, and title of certifier	and mainer	olalog.		29c. Licen	nse number	29	9d. Date sign	ned (Month	n, Day, Year)		
	⊢ s ⊢ ŏ		boon Bl	al n	10		00	061199	1		·	,		
	Í					23a) (Type								
	V		Jason Black	6601	Worn	1 Cho	rles Si	t. Tous	on M	0 2	120	4		
	Sta	te	31. Date filed (Month, Day, Year)		strar's Signat	ure		3				-		
	Registr		APR 1 0 201	16	. Ac	Apar	KI							
D	HMH 17 Rev 1/2	001		The state of the s		1								

ORIGINAL

6-02323 Dx, <b>Mathew</b>	Stat	e of Maryland / Depart	rint in Black Indeli ment of Health and ficate of Death	Mental Hygiene	2006 11	0.0
Physician/	Registrar  1 Decedent's Name (First, Middle,L		icate of Death	Re 2. Date of Death Month	Day Vees	eath
Medical Examine	4a. Facility Name (if not institution, s Sinai Hospital		4b. City, Town, or Lo	April 4, 20		′A
Funeral Director	216 32 2727	Sex 7. Age (In yrs. last	birthday) If Under 1 Year Months Days	Hours Min.	h (MM/DD/YYYY) 9. Birthplace (State Country)	
w any	Usual Residence of Decedent 10a. State 10b. County		wn or Location		10d. Inside C	
th the Maryland 23a or 28a-f show notified at once.	MD BAI 10e. Street and Number	_TIMORE E	BALTIMORE 10f. Zip Code	10	g. Citizen of What Country?	X
er death with the N or items 23a or rmust be notified Funeral Dir	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No ed If Yes, Give Year or Dates:	If Yes, specify Cuban, N		White, etc.  Specify: WH	
5-0036 led within 72 hours after the within 72 hours after the figure other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)	6a. Decedent's Usual Dccupation ring most of working life. DO NOT STUDENT		16b. Kind of Business/Industry  STUDENT	
210 be fill nital li riked ent,	MICHAEL	F	OX	Mother's Name (First, Middle, N	LONDON	Į
Baltimore, MD 21 permit Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic ev	MICHAEL FOX / 20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other Spec 21. Signature of Funeral Service Lice	FATHER  3 Removal from State Creify: BALT	8 BARSTAD COUR ce of Disposition (Name of cemel matory or other place) TIMORE HEBREW C 22. Name and Address of	T - LUTHERVILL tery, Date  EM. 04/06/2006 Facility SOL LEVINS	20c. Location - City or Town, State REISTERSTOWN, ON & BROS., INC.	
Physician /Medical Examiner	23a Part I. Enter the disease, or co failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	mplications that caused the death. Due to (or as a consequence of):		RSTOWN ROAD - ch as cardiac or respiratory arre	BALTIMORE, MD 212 Approxima Between C	ite Interva Onset and
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<ul><li>b. Due to (or as a consequence of):</li><li>c. Due to (or as a consequence of):</li></ul>				
and and	V UNDENDED	d. X AMENDED item#1,23a	a,27,28a-f,perME,g8	856,6/14/06 TT		
<ol> <li>Box 68760, the death certificate be eby the attending physicia ched for use as the burianched for use as the burian.</li> </ol>	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnar 1 Live birth 4 Pregnant at time of death	ncy 2 Fetal death 3	Ectopic pregnancy	23d. Date of delivery Month Day	Year
P.O. Be res that the de signed by the be detached for the		s contributing to death but not resu	ulting in the underlying cause give		bacco use contribute to the cause of c	
Records,  The law requires, freate has been sig. page 2 should be				24a. Was a autop perfor 1 ✓ Yes	sy prior to completion of oned? death?	
f Vital Physician Printiple certification Printiple Company Printiple Printi	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	28a. Date of Injury (Month, Day, Year) Unknown	R/Outpatient 3 DOA Ot 8b. Time of Injury 28c. Injury 1 Yes	-	Residence 6 Other: now injury occurred ingested drug	
Division o spital or Attending hours after death neral Director: After filled in by the fune	2	gation 3/28/2006 1 28e. Place of Injury - At hom	unk e, farm, street, factory, office buil	ding, etc. 28f. Location (S	Street and Number or Rural Route Nur tate) 7906 Long Meadow R	
To the Hosp within 24 ho To the Fune completely f		sician: To the best of my knowledge ner:On the basis of examination and and manner stated.	or investigation, in my opinion, o	and place, and due to the caus death occurred at the time, date	e(s) and manner as started. and place, and due to the cause(s)	
	30 Name and address of person wi		29c. License r O.C.M 3a) 111 Penn Street, Baltimo	E.	April 5, 2006	/
Stat Registra DHMH 17 Rev 1/200	APR 1 0 201		Sparke ORIGINAL			
OCME 10/2003						

11

		1 - State	State of Ma	arylan	-	artment of F		nd Mental Hy	2000	11022
Physici	an	Registrar  1. Decedent's Name (First, Middle	Last)			imodio or	Douin	2. Date of De	Reg. No. ath Day Year	3. Time of Death 2 45 PM
/Medic Examir		4a. Facility Name (If not institution,	Λ1.	v 1-	Lone.	4b. City, Town, o	r Location of	Death	4c. County of De	ath
Funeral Director		5. Sociaf Security Number 246-70-7261			ast birthday) 61 Yrs.	If Under 1 Year Months Days	if Under 2 Hours	4 Hrs. 8. Date of Bir (Month, Da	th 9. B	inthplace (State or Foreign Country) th Carolina
show	ō.	Usual Residence of Decedent  10a. State 10b. County			, Town or Lo					10d. Inside City Limits 1 ☐ Yes ※XX No
with the M a or 28a-f	Directo	Maryland Baltin  10e. Street and Number		Cato	nsvill	10f. Zip Code			10g. Citizen of What C	Country?
is 5, Middly judical K. 12.15.70000 s 1 and 2 should be filled within 72 hours after death with the Maryland f Health and Mental Hygene. Item 27 is marked other than "natural; or Items 23a or 28e-f show other traumatic event. Its Medical Expirator manker colling at	by Funeral	701 Edmondson Av  11. Marital Status  1XXI ever Married 2 Marri 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?			21228  Was Decedent of H f Yes, specify Cubin  □ Yes   □ Yes	dispanic Origi an, Mexican, Specify:	in? (Specify Yes or No Puerto Rican, etc.)	Specify:	nerican Indian,
ithin 72 houndless	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	s Education	5+)	(Give	lent's Usual Occup kind of work done DO NOT use retired	during most	of working	16b. Kind of Busines	
Mental Hygiene.  Mental Hygiene.  arked other ther	Be	17. Father's Name (First, Middle, I	ast)		Mi	1 Right	18. Mother	's Name (First, Middle	Saw Mill , Maiden Sumame)	
i, IVICAL Y ICALINATE and 2 should be salth and Mental n 27 is marked one traumatic even	2	Gus Barnett  19a. Informant's Name/Relationsh Hattie M. Sauble					and Number	Gardner or Rural Route Numb York, PA	er, City or Town, State,	, Zip Code)
ILL Page rtment o rtant: If njury or		20a. Method of Disposition  1 Burial 2 Toremation  4 Donation Donation Service  21. Signature of Fund Service	3 □Removal from State	Baf	lace of Dispo emetery, crer timore oudon		ry A	pr. 14, 006	20c. Location - City of	• Maryland
Dermi Depa Impo		Jano Osmai	com- ications that caused	the death				3620 Wilke Baltimore,	ns Avenue Maryland	21229 Approximate
The law requires that the death certificate be executed was been signed by the attending physician and case as the burial-transit or see as the burial-transit or	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Miller) that initiated events resulting in death) Last	a	a consequ	uence of):	h'ces	aga	ed a	Bcess	Interval Between Onset and Death
w requires that the death certificate that the death certificate been signed by the attending pt should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	]Ectopic pregnanc ] Other (specify)	у		23d. Date of d Month	lefivery Day Year
quires that quires that en signed by ruid be deta	b	Part II. Other significant condition	contributing to death b	out not resi	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did 1	robacco use contribute Yes 2 No 3	to the cause of death?  Probably 4 □Unknown
The lawre cate has bee	Completed		Inpue	W	er			24a. Was auto perfo 1  Yes	an 24b. Were prior to death' 22 No 1 1 Ye	
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 2 56  27. ann of Death  1 Vaturaf 5 Pendin 2 Accident investig		iry	ER/Outpatier 28b. Time o Injury	28c. Inju	ner: 4	28d. Describe	one)\ dence 6 □Other (Sp how injury occurred	necify)
Lal or Atter s after dea al Director ed in by the	Certification:	3 Suicide 6 Could r 4 Homicide determ		jury - At ho tc. (Specif	ome, farm, str	eet, factory, office		28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number,
the Hospi hin 24 hour the Funer npletely fill	edical	(Check only 2 Medical one)	g Physician: To the best Examiner: On the basis of and manner st	f examina	wledge, deat tion and/or in	vestigation, in my	opinion, death	place, and due to the n occurred at the time,	date and place, and d	ue to the cause(s)
5 W 15 OO	Σ	29b. Signature and title of certifier	Approximated source of	Clasth (4a-	2311 (7:00	29c. Licens	000	57897	29d. Date signed (Mo	-06
St	ate_	30. Name and address of person 31. Date filed (Month, Day, Year)	ADO CUT	M	0 9	055 0	ber	sig In	reste	100 WILLIAM
Regist	rar	APR 1 0	2006	الله الله	1					

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician 2006 7:30 A M APRIL BERTHA GASPREDES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** 1 □ M Yrs. Director 88 PA 196.09.3745 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2☐ No Directo ANNE ARUNDEL SEVERNA PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21146 USA 604 MCKINSEY PARK DR. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2XXVo If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☐ No XX Specify. 3√Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be s 1 and 2 should be fi f Health and Mental H item 27 is marked ot BARBARA 2 MICHAEL KORAL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2033 BRIARCLIFF RD. LOUISVILLE, TX 75067 EDWARD GASPREDES SON other Baltimore, 20b. Place of Disposition (Name of 20a, Method of Disposition 20c. Location - City or Town, State Pages 1 permit. Pages 1 Department of H Important: If ite eny injury or ot once. cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) GLEN HAVEN CEMETERY 4.8.2006 GLEN BURNIE, MD 21. Signature of Funeral Service License 22. Name and Address of Facility
FINK FUNERAL HOME, FINE P.A. GREGORX I MO1148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (3)'s a consequence of): phennonia nows /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed the burial-transit assivation Due to (or as a consequence of) Completed by Physician/Medical use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Day Month Year 5 Other (specify) signed by the at d be detached fo 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 Ne 3 Probably 4 Unknown pinous been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 20 No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? director Certification; To Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Natural 5 Pending i Director: Af 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 🔲 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 3/06 D62242 of person who completed cause of death (Item 23a) (Type, Print) 0 >ullivay 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of M	aryland		artment of H		nd Mental	Hygie	time and the time	11024	
	Physicia		1. Decedent's Name (First, Middle, Las						2. Date Mont	of Death		3. Time of Death	
	/Medic	al	A. F. W. N	LEONARD				ENFIEL		L 6,	2006 Year 4c. County of Death	10:56 A M	
	Examin	er	4a. Facility Name (If not institution, given HARFORD MEMORIAL		_		4b. City, Town, or HAVRE	DE GR			HARFORD		
	Funeral Director		5. Social Security Number 6. S		ge (In yrs. Id 67	ast birthday) Yrs.	If Under 1 Year Months Days		Min. 8. Date	of Birth	9. Birth	place (State or Foreign intry) PA	
pur	3		Usual Residence of Decedent  10a, State 10b, County		10c. City	, Town or Lo	cation					10d. Inside City Limits	
Maryl	fed at	ţō	,	ECIL			OWINGO					1 ☐ Yes 2 🔀 No	
th the	or 28a e notil	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of What Cou	untry?	
eth w	23a mat b		143 E. RED HILL					219				USA	
2 should be filed within 72 hours after death with the Maryland	il', or iteme 23a or 28a-f ehov kaminer must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12, Was Decedent Armed Forces 1 X Yes 2 ☐ If Yes, Give Year or Dates:	?	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Origir in, Mexican, F Specify:	n? (Specify Yes Puerto Rican, et	or No- c.)	14. Race - Amer Black, White Specify:		
72 hou	natura Jical E		15. Decedent's Ec (Specify only highest gra	fucation de completed)			dent's Usual Occup		of working	166	. Kind of Business/I		
within 5	if Heelth and Merial Hygiene. Item 27 is marked other then "natu other treumatic event, the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	OWNER	DO NOT use retired	()	ar working	MO	CDONALDS 8	DONUTS & DUNKIN	
d be file	and Mental Hygiene. Ie marked other then eumatic event, tre Mi	To Be (	17. Father's Name (First, Middle, Last) MORRIS		GI	REENFI	ELD		s Name <i>(First, M</i> LVIA	liddle, Maid	den Sumame)	COHEN	
d 2 shou	treumet	-	19a. Informant's Name/Relationship ( THERESA GREENFI	• • • • • • • • • • • • • • • • • • • •	F		ng Address (Street :				ity or Town, State, Z.		
Pedes 1 and	Depertment of Heelth Important: if item 27 eny injury or other tre		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 📉		20b. P	lace of Dispo emetery, crer	sition (Name of matory or other place	(e)	Date	200	c. Location - City or 1	fown, State	
rmit. Pe	pertmen portant: y injury ce.		4 □ Donation 5 □ Other (Specification 21. Signature of Juneral Service Licer	<del></del>	KIN		D CEMETEI		4/07/200 SOL LE		ENSALEM, ON & BROS.		
3 8	Depe Impo eny f		Acath 111.	unte	<u></u>				OWN ROAD	- PI	KESVILLE.	MD 21208	
,*	hysician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each I	ine.	. Do not ent	1.1 -	- 0	ardiac or respirat	ory arrest,		Approximate Interval Between Onset and Death	
	Medical xaminer			b. Coro	a consequ	uence of):	Herry d	is eas	e.				
petn	d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	aconsect	ence of):	lecteral	and	trigle	3(20/10	ler		
be exec	sicien end burial-transit		resulting in death) Last	Due to (or as	a consequ	uence of):			,				
ificate	g phys as the	edical		d									
De death cert	within 24 hours efter deeth. To the Funerei Director: After this certificete hes been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)	1			23d. Date of deliment	very Day Year	
s that t	igned by be detai	by Ph	Part II. Other significant conditions of	ontributing to death t	out not resu	ulting in the u	nderlying cause giv	en in Part I.	23e.	Did tobac	co use contribute to	the cause of death?	
aouire	been sig should b		Depression						_	1 Yes	2 □ No 3 □ Pro	obably 4 Unknown	
The law o	ete hes be page 2 sh	Completed							_	Was an autopsy performed Yes 2 2	prior to o death?	topsy findings available completion of cause of	
V ILO	certific rector,	Be	25. Was case referred to medical examiner?	Hospital:		,	oth Oth	05	of Death (Check				
2 5	ar this eral di	ت: ح	1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Inj (Month, Da		ER/Outpatier 28b. Time of	II 3 DOA	4 🔲 Nurs			e 6 Other (Specinjury occurred	erfy)	
	or: Afte	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	n	ay Year)	Injury		k? Yes 2 ☐ No	0				
NIVIN I	s efter de	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of in	ijury - Al ho tc. <i>(Specil</i> y	me, farm, str	eet, lactory, office			tion (Stree or Town, S	et and Number or Ru State)	ral Route Number,	
te Hospit	within 24 hours effer deeth.  To the Funerei Director: After this certificete hes completely filled in by the funeral director, page 2.	edical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner s	of examinal	wledge, death tion and/or in	h occurred at the tir vestigation, in my o	ne, date and pinion, death	place, and due to occurred at the	o the caus time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
To	To the	M	29b. Signature and title of certifier	le (80)	my	)	29c. Licens	e number 0339	125	29d.	Date signed (Month)	n, Day, Year)	
			30. Name and address of person who	completed cause of	v M	1)	1 Queen	C	RISING.	(un/	MD al	1911-08 48	
13	Sta	ate	31. Date filed (Month, Day, Year)	32. Regist	trar's Signa	ture	book	01.	12116	7411	1 1 0 1	111 00 10	
DUI 4	Registr		APR10	2006	Sept Stand	A. A	goese.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year Denneal Elise Huminski Physician 05 A M 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** OSPITAL OF DALTIMORE Year HUnder 24 Hrs. Birthplace (State or Foreign \_\_Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 8. Funeral Days 1□M 2\XF Months Hours Min. 513.82.2952 30 10/10/1975 Kansas Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at Director Md Glen Burnie 1 ☐ Yes 2 X No Anne Arundel 10f. Zip Code 21061 the 10e. Street and Number 10g. Citizen of What Country? 6 USA 270 Woodoak Ct. "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 1 No If Yes, Give A Year or Dates: 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, Ira Ma Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ronald Robinson Verna Kruse 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Huminski 270 Woodoak Ct. Glen Burnie, Md 21061 20b. Place of Disposition (Name of cometery, crematory or other place)
Sunrise Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04-11-2006 Manhattan, Kansas 22. Name and Address of Facility Witzke Funeral 5555 Twin Knolls Rd. Columbia, 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death tmmediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner o ta a 21 V canles sequentially literactions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burlat-transit The law requires that the death certificate be executed 10 M 0 Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day in the past 12 months? Year 5 Other (specify) 1 ☐Xes 2 ☐ No he 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe 1 ☐ Yes 2 ☐ No 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 X Inpatient 2 ER/Outpatient 3□ DOA After thi 27. Manner of Dath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification Natural 5 Pending investigation after death.

I Director: After din by the fur 1 🗌 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res 000 04 05 06 oad a Name and address of person who completed gause of death (Item 23a) (Type, Print) 40 2/215 QQ. a Darie, Daltimore 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

APR 1

0 2006

ORIGINAL

**ORIGINAL** 

DHMH 17 Rev 1/2001 OCME 10/2003

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** APRIL 7, 2006 8:22 A WILLIAMSON HEDDING /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Oeath **Examiner** 2445 BLUE SPRING CT. #303 ODENTON ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months M 2□F Days Hours Min. **Director** PA 522.38.2994 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director MD ANNE ARUNDEL ODENTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a USA 2445 BLUE SPRING CT. 21113 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 12. Was Decedent Ever in U.S. Armed Forces?

Yes 2 □ No 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ģ 3₩Vidowed 4 Divorced Year or Dates: XX WHITE 'naturel' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) DEPUTY COMPTROLLER US GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be fi and Mental F is marked of iit. Pages 1 and 2 should be artment of Health and Menta ortent: If item 27 is marked FRED HEDDING MARY OVERHOLT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALICE NICHOLAS AGENT 8019 TELEGRAPH RD. SEVERN, MD 21144 other t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BAYVIEW CREMATORY, INC 4.8.2006 BALTIMORE, MD permit.
Departnimporte 21. Si it re of Funeral Service License FINK FUNERAL HOME, P.A. GREGORY FINK MO1148 426 CRAIN HWY SW GLEN BURNIE, MD 21061 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, for heart failure. List only one cause on each line, Approximate Interval Between Onset and Death shock or heart failure. Immediate Ocuse (Final disease or condition resulting in death) Priysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed burial-t Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☑ No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 🗆 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA <sup>o</sup>L Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Hospitel or Attending 5 Pending investigation 1. Natura within 24 hours after death. To the Funerel Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier Name and address of person who comple ed cause of death (Item 23a) (Type, Print) DEFENSE HIGHWAN HANAPOLI MD 21401 MICHAER GIENTA M 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛭 🗎 🖺 1- State AMEND Item 21 per DVR, 04/10/06 detricate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Vaar Physician 3:33 PM MARCH ZE HOUSE 2006 JOHN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL (ENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1**X**M 2□ F 220-22-4222 Yrs. 79 10/09/1926 South Carolina Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County ne 23a or 28e-f show must be notified at ¥Yes 2 □ No MD Baltimore City Director 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 2544 West Pratt St. 21223 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) r than "nstural", or Iteme Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed by 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Supervisor Monroe Uphostery 6th grade other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill iment of Health and Mental H lant: If Item 27 is marked ott Be 2 James House Louise Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn House (wife) 2544 W. Pratt St., Balto., MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Depertment of H Important: If Ite any Injury or ot once. □ □ □ □ □ Cremation 3 □ Removal from State 04/04/2006 Woodlawn, MD King Memorial Park 4 ☐Donation 5 ☐ Other (Specify) Dietrich Williams per DVR

Joseph H. Brown, Jr., Funeral Home, 2140 N. Fulton Ave., Balto., MD 21217

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, specific for the complete of the co Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** EMBOLISM TULMONARY /Medical Due to (or as a consequence of): Examiner PNEUMONIA WEEK MULTILOBAR Securitally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): WEEKS or Attending Physician: The law requires that the death certificate be executed iding physicien and ise as the burial-transit I BERZULOSIS resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 🗆 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 @Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Tyes 2 No 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending s after do. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funerel DI 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier, 29c. License number RES-000 2006 MARCH 28

Registrar

State

4940 EASTERN AVENUE BALTIMORE MD 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

JEFFREY HIGHFILL

APR 1 0 2006

31. Date filed (Month, Day, Year)

		1 = For State Registrar	State of Maryland		rtment of H			giene	6 110	29	
Physic /Med Exami	ical	Decedent's Name (First, Middle, L	O HILL		4b. City, Town, or	Location of Deat	2. Date of De Month	Day	3. Time of 2 3 of Death	of Death	
Funera	1	BALTIMORE REHABLES. Social Security Number 6.	LITATION EXTENDE Sex 7. Age (In yrs. I XXM 2 F 88		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	th ly, Year)	9. Birthplace (State Country) MD	or Foreign	
D		Usual Residence of Decedent  10a. State 10b. County		, Town or Lo	cation		104. 1	4 1/	10d. Inside C		
ith the Ma or 28a-f s	Directo	MD NA 10e. Street and Number	Ba	ltimo	10f. Zip Code			10g. Citizen of W	1 ☐ Yes 2 ☐ No Citizen of What Country?		
ING KILIS-UUSO  be filed within 72 hours after death with the Maryland hat Hygiene.  d other then "natural", or items 23s or 28s-f show event, the Wedical Examinar must be rediffed at	by Funeral Director	2330 West Lex  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces?	S. 13. \	212 Nas Decedent of H f Yes, specify Cuba		Specify Yes or No to Rican, etc.)	U.S 14. Race Black Specify:	- American Indian, c, White, etc.		
within 72 hou iene. Then "nature in wedical in	Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		(Give lite.	lent's Usual Occup kind of work done o OO NOT use retired	during most of wo l)	rking	16b. Kind of Bu	siness/Industry	_	
tha CICI be filed within tal Hygiene. d other then "	Be Cor	12th grade  17. Father's Name (First, Middle, La	na na	F	Ingineer		me (First, Middle	Montgoi , Maiden Sumami		ds	
raryiar 2 should be and Menta is marked reumatic ev	70	John Wesley H  19a. Informant's Name/Relationship		19b. Mailir	g Address (Street	Mary Stand Number or R		er, City or Town,	State, Zip Code)	21223	
baltimore, Marylar particle. Marylar permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic enones.		Marjorie Hill  20a. Method of Disposition  XXBurial 2 □ Cremation 3  '4 □ Donation 5 □ Other (Spe	Removal from State	lace of Dispo emetery, crer	sition (Name of natory or other plac	(9)	Date	20c. Location -	ltimore, City or Town, State	Md	
permit. Pages Department of Importent: If is any injury or		21. Signature of Funeral Service Lic	ensee Holications that caused the dealth	00 M 5	Name and Address Rich F/H 800 Waba	ss of Facility   West  sh Ave	, Balti	more,	Md 2121 Approxima	5 ate	
Physician /Medical		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	ly one cause on each line.  a. ADENO CA  Due to (or as a consequ	ARC/	NOMA	ESOP.	HAGU	15 W/	The Interval Be Onset and		
ate be executed by the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of the consequence)		5 70	O CIL	IER				
OX OS / DU Certificate be e Iding physiciar	fedical	A.	d								
death death e atter	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3		23d. Date Mor	e of delivery ath Day	Year			
cords, F.C w requires that the been signed by th should be detache	by	Part II. Other significant conditions	s contributing to death but not result of the second of th	ulting in the u	nderlying cause giv	en in Part I.			ibute to the cause of 3 Probably 4		
The lar	Completed						1 ☐ Yes	psy p ormed? d 2.0x1No 1	Vere autopsy findings rior to completion of eath? Yes 2 \( \) No	available cause of	
OT VICAL Physician: T this certificat ral director, pa	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	1	ER/Outpatier		er: 4 <b>⊠</b> Nursing I		idence 6 Othe			
To the Hospitel or Attending Phys within 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral director.	ertification:	27. Manner of Death  1 X Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	be 29a Bloom of Injury. At he	28b. Time o Injury	M 1	yat k? Yes 2 □ No	28f. Location (		ed er or Rural Route Nur	mber,	
pitel or / burs after lerei Dire	O	4   Hollicide	building, etc. (Specify Physicien: To the best of my kno	y) 		ne date and plac		wn, State)	nnar as stated		
the Hos thin 24 h the Fur mpletely	Medical	(Check only one) 2 Medicel Example 29b. Signature and title of certifier	eminer: On the basis of examina and manner stated.	tion and/or in	vestigation, in my o	pinion, death occ	urred at the time,	, date and place, a	(Month Day Year)		
F Z F 8		I Shen 9	Hashmi	M	020	9648	>	04-06	-2006		
4+1		30. Name and address of person w	SHMI MD 30	900 L	Print)	NBIVE	BALTI	HOLE M	10 2121	P	
Regis	tate trar	31. Date filed (Month, Day, Year) APR 1 0 2	2006 Registrar's Signa	Apple	ules						

_			1 - For State Registrar	State of	Marylan		artmen <i>rtificat</i>					giene Reg. No.	006	and the second s	30
	Physici /Medi		1. Decedent's Name (First, Middle Baby Girl Har								2. Date of De Month	Day		ır .	of Death bPM
	Examir		4a. Facility Name (If not institution	n, give street and numb		intiac	4b. City,	Town, or	Location	of Death			County of Di	more	
H	Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs.	last birthday	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th Year)		Birthplace (State Country)	or Foreign
¥	Director		none	1 □ M 212 F		Yrs.		04,0	4	17	Mar 24		06 Ma	ryland	
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or L	continu							10d, Inside	City Limite
	anyla shov	_	Tod. State		100. 01	ty, TOWN OF E	DOMINIT								s 2 No
	Ba-f	ecto	MD		Bal:	timore									
	with t	ā	10e. Street and Number				10f. Zip	Code				-	zen of What	Country?	
	death with the Maryland me 23a or 28a-1 show	rai	1623 Kings Way		Land Francis III	10		218			7 77 11	USA	14.5	and the first	
Baby Gir 21215-0036	s after de , or Item	by Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ Mar  3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	es? !⊠No	13.	If Yes, spec				cify Yes or No Rican, etc.)	)-	Black, W Specify:		
Baby 6,	hour ural	pg p			es:	10- D	death bloom	10	-41			405 10		lack	
₫ <del>1</del>	"nat	Completed	(Specify only highe	t's Education st grade completed)		(Give	dent's Usua kind of wo DO NOT us	rk done a	turina mos	st of worki	ng	16b. Kii	nd of Busine	ss/Industry	
2 2	withii Bne. than	ш	Elementary/Secondary (0-12)	College (1-4	4or 5+)		2071078	,0,1,1,00,	,						
	Hyginther ther	ပိ	none 17. Father's Name (First, Middle,	none		none			18. Moth	er's Name	(First, Middle	none Maiden			
and	d be ontal	o Be		·											
	nd Me	2	Bernard Harris  19a. Informant's Name/Relations	shin (Type Print)		19h Mail	ing Address				larvey  J Route Numb			Zin Code)	
Nary!	d 2 s th ar 27 is trau		Franklin Square				-								222
A DRUE	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or iteme 23a or 28a-1 show any injury or other traumatic event, the Madical Examiner must be inclifted at once.		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Prother (5	3 □Removal from St	tate	Place of Disp cemetery, cre	osition (Nar.	ne of		are 1	TIVE,	20c. Lo	Imore cation - City	MD 212 or Town, State	37
Balti	permit. DepartmImporte any inju		21. Signature of Funeral Sovice			r S	2. Name an tate altim	Anat	omy I	Board	655 W	. Bal	timor	e Stree	t
	Pnysician		23a. Part1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on eac	used the deat ch line.	20	V. 28 0	e of dying	-	cardiac o	0000	rrest,		Approxim Interval B Onset an	etween
88760,	Medical Examiner be executed by Medical Examiner buy site private transit	dicai Examiner	Sequentially list conditions, flany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Que (5)	r as a conseq	uunaa of):	ager	) ES	15						
.O. Box 6	Physicien: The law requires that the death certificate be this certificate hes been signed by the attending physicie rai director, page 2 should be detached for use as the bur	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta nt at time of d	al death 3	⊒Ectopic pr ⊒ Other (sp					2	23d. Date of Month	delivery Day	Year
Division of Vital Records, P.O.	w requires that been signed b should be deta	Ď	Part II. Other significant conditi	ons contributing to dea	ith but not res	sulting in the o	ınderlying c	ause give	en in Part	l.				e to the cause of	
Reco	The law re te hes bee age 2 sho	Completed										psy ormed?	prior		s available cause of
ta	ysicien: The is certificate hu director, page	BeC	25. Was case referred to medica	1					26 Place	a of Death	1 ☐ Yes		1 🗆 Y	'es 2□ No	
5	ysici s cer direct	ToB	examiner? 1 ☐ Yes 2 ② No	Hospital: 1 X Inj	natient 2	ER/Outpatie	nt 3 DC	Othe	200		ne 5∐ Resi	•	S MOther /S	(necifu)	
on of	Afte Afte		27. Manner of Death  1 X Natural 5 Pendii 2 Accident investi	28a. Date of (Month)		28b. Time of Injury		8c. Injury Work		1	28d. Describe			рвопу	
Divisi	or Attending after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	of Injury - At ho g, etc. (Specif	ome, farm, st	reet, factory	, office			28f. Location ( City or To	Street and wn, State	d Number or	Rural Route Nu	mber,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edicai C	29a. Certifier 1 Certifyin (Check only one) 2 Medical	ng Physician: To the b Examiner: On the bas and manne	is of examina	owledge, dea ation and/or in	th occurred nvestigation	at the tim	ne, date ar pinion, dea	nd place, a	and due to the ed at the time,	cause(s) date and	and manner place, and o	as stated. due to the cause	(s)
	To th To th comp	Me	29b. Signature and title of certifie	er			290	. License	number			29d. Dat	e signed (Mo	onth, Day, Year)	
			1 Roll	and and			•	1 3	11 02	11		m.	006	DIL ON	010
			30. Name and address of person	who completed cause	of death (Item	n 23a) (Type	, Print)	) (	<u>۱۱ - ۱۷</u>	70		1110	KUT.	24, 20 nore, Mi	W
çije	No or to	10	31. Date filed (Month, Day, Year,	CORLUS	gistrar's Signa	1 UUO	-11	wn	KII	20	make C	JK. 17	JUHIN	noke, Mi	2 31331
	Sta Regist		APR 1 0	2006	gistrar's Signa	K Go	and I								

DHMH 17 Rev 1/2001

ORIGINAL

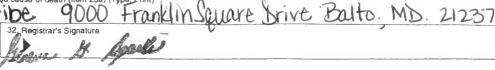
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗍 🗎 🔓 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** O Öl 2006 Baby Boy Hammond /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Sedale saltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 1⊠M 2□F Hours Yrs. Director April 2006 Maryland Usual Besidence of Decedent 10a. State 10c. City, Town or Location 10b. County or 28a-f show 10d Inside City Limits the Medical Examiner must be notified at Director 1- Yes 2 □ No MD Baltimore Hammond, Babuba 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? "neturel", or items 23a 930 Thompson Road Funeral 21221 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be tiled within Department of Health and Mental Hygiene. Important: If Item 27 is marked other then eny injury or other traumatic months. Elementary/Secondary (0-12) College (1-4or 5+) none none none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael Shane Welch Nicole Marie Hammond 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Franklin Square Hospital 9000 Franklin Square Drive, Baltimore, MD 21237 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 AOther (Specify) in state 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Ronald ixector State Anatomy Board 655 W. Baltimore Street Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) signed by the a Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? certificate 1 ☐ Yes 2 No Division of Vital 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide hours after within 24 hours a To the Funeral ( 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of centities 29c. License number 29d. Date signed (Month, Dev. Year) 2006

State Registrar

DHMH 17 Rev 1/200

APR 1 0 2006

31. Date filed (Month, Day, Year)



completed cause of death (Item 23a) (Type Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State RegistrerAmend Item 4b per DVR, G854, 04/10/06 Reprisincate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 31 Physician A M 2006 Name (If not institution 0 /Medical 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore
If Under 1 Year If Under 24 Hrs. yrs. last birthday) 8. Date of Birth (Month, Day, Ye 6 - 20 - 38 Birthplace (State or Foreign Country)
 MD Social Security Number 7. Age **Funeral** Days Months Hours Min 1**∏**M 2□F 67 219-26-3831 Yrs. Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits rthan "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at MD Baltimore 1 XYes 2 No Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21229 2909 Roslyn Ave. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ XXNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry event. the Ma Elementary/Secondary (0-12) College (1-4or 5+) City 12th Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I int: If item 27 is marked of item 27 is marked other traumatic ev Bill Hopkins Hilda Henson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) %9 Broadway Hagerstown, MD 21740 Tammy Henson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If its eny injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Carmel 4-6-06 Dundalk, MD 22. Name and Address of Facility Wesley Chavis, Jr. FH 2007 Eastern Ave. Balto.MD 21231 Mount Carmel 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deat Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** MON /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner physicien and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medicai as the IF FEMALE: US6 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 2 🗆 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete hes t lirector, page 2 s autopsy performed? 2111Vo 1□ Yes Division of Vital Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 Chricatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 2 1 10 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 28b. Time of 28d. Describe how injury occurred 1 D Haturat 2 ☐ Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ∩ 24 hou. the Funeral Dire Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely within 2 To the ţ 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) ပ

State Registrar H. NON

31. Date filed (Month, Day, Year)

APR 1 0

2006

DHMH 17 Rev 1/2001

h (Item 23a)

32. Registrar's Signature

	1 = For State Registrar		Maryland	-	artment of F		and M	Re	ag. No.	)	11033	
Physician /Medical	Decedent's Name (First, Middle, L		rt B. Joh	nnson				2 Date of Deat Month April		Year	3. Time of Death	
Examiner	4a. Facility Name (If not institution, gi			A Disab de la	4b. City, Town, o  Baltim  If Under 1 Year					NA		
uneral rector	5. Social Security Number 6. 215- 22- 6942  Usuaf Residence of Decedent	Sex 1 M 2 ☐ F	Age (In yrs. las	Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day, 01–04–192	Year)	Virgi		
a-f show	10a. State 10b. County MD NA		10c. City,	Town or Lo	Baltimore					10d. Inside City Limi 1 <b>∑</b> Yes 2 ☐ N		
23a or 28 at band ai Direc	10e. Street and Number 1005 Walmut Avenue				10f. Zip Code 212:	29		10	0g. Citizen of W	nat Cou	ntry?	
marked other then "naturel" or Items 23s or 28s-f show unalic event, the Medical Exambar must be notified at To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceder Armed Force: 1  Yes 2 If Yes, Give Year or Dates	s? ¶No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2XNo		gin? (Spe i, Puerto l	cify Yes or No- Rican, etc.)	Specify:	- Ameri , White, Black		
then "natur he Madical hempleted	15. Decedent's I (Specify only highest g Elementary/Secondary (0-12)			(Give	dent's Usual Occup kind of work done DO NOT use retired Driver	durina most	t of workii	ng	16b. Kind of Bus	iness/In	dustry	
atic event, il To Be Co	17. Father's Name (First, Middle, Las William Johns				Driver	18. Mothe	r's Name	(First, Middle, M	Aaiden Surname	ickir	ıg	
₩ 근	19a. Informant's Name/Relationship Muriel Tucker/ Fri				ng Address <i>(Street</i> 205 Walnut <i>1</i>					tate, Zip	Code)	
Important: If Item 27 Is any injury or other tra once	20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Special Control Co		te cen	ce of Disponetery, crema	esition (Name of matory or other place ntory	. 1	04 <b>-</b> 06		20c. Location - C Catonsvill			
Importe any nji	21. Signature of Funeral Service Lice	gones			Name and Addre		•	638 N. Gil	lmor Stree	et Ba	Ito, MD 21	
physicien and leads is the burial-transit and leading leads in the burial transit and leading	d										Onset and Death	
d by the attending prietached for use as it	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal dat time of dea	eath 3	Ectopic pregnancy Other (specify)				23d. Date Mont		ery Day Year	
ed by Pr	Part II. Other significant conditions	contributing to death	but not resulti	ing in the u	nderlying cause giv	en in Part I.					he cause of death? pably 4 Unkno	
cate has been s page 2 should Completed				<u>-</u>			_	24a. Was ar autops perform	pr ned? de	or to co ath?	opsy findings availa mpletion of cause 2  No	
To the Funeral Director: After this certificate has been signed by the attending physi completely filled in by the tuneral director, page 2 should be detached for use as the Medical Certification; To Be Completed by Physician/Medical	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigating 2 Accident investigating 3 Suicide 6 Could not determine	28e. Place of I	njury 2. Day Year)	8b. Time of finjury	Wor	er: 4 □ Nu: v at	rsing Hon 2 No	Check only one ne 5 Reside 28d. Describe ho	nce 6 Other w injury occurrer	d	'y) al Route Number,	
Funeral Dir letely filled in dical Cert	29a. Certifier 1 Certifyin P	hysician: To the bes	st of my knowl					ind die II. the da	usc(s) and men			
To the F complete	29b. Signature and title of certifier  30. Name and address of person who	and manner	stated.  I death (ftem 2	(Type,	29c. Licens	e number	186	5 /	9d. Date signed	(Month,	Day, Year)	
	31. Date filed (Month, Day, Year)	32 Balls	strar's Signatur	1. 17	TENES	HO.	501	172	BITT	771	more.	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Oate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Cedric Jackson 02, 2006 Darry1 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a: Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPITAL GOOD SHIMARITHN If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 M 2 □ F 212-56-4720 Director 7 -10-1951 Md Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d, Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other treumatic event, Ite Madical Exam net must be redified at 1 ☐ Yes 2 ☐ No Director MdN/A Balto 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6704 Fordcrest 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Yes ZHNo Baltimore, Maryland 21215-0036 Specify Black þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry Manager Information Services B G & E Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Lou Burrell George E. Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila D. Jackson - Wife 6704 Fordcrest Road Balto, Md 21237 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Importent: If any injury or once. \* 4 □ Do ation 5 □ Other (Specify) 3 - 8 - 2006Catonsville, Md Metro Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West Shompson 4300 Wabash Avenue Approximate Interval Between On a 1 nd Death inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one caus an each Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical quence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed the burial-transit O. Box 68760 Be Completed by Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ned by the atten detached for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown م. ontributing/to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions of Records, sign I be 2 🗆 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy 20 1 Yes Division of Vital funeral director 25. Was case referred to medical 26. Place of Death (Check only one) 20 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 Tyes 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this nann of D 1 atural 28a. Date of Injury (Month, Day Year) of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After To the Hospital or Attending 5 Pending investigation within 24 hours efter death.

To the Funerel Director: Af death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could of be 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of py knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[A] Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29d. Date signed (Month, Day, Year, 29b. Signat 10 Samaritan 31. Data filed (Month, Day, Year) State Registrar

				State of Maryland / Dep		=	ne 2006	1035
		Physici /Medio		Decedent's Name (First, Middle, Last)     Raymond Johnson		2. Date of Death	Day Year	3. Time of Death 5:35 PM M
		Examir		4a. Facility Name (If not institution, give street and number)  Joseph Richey Hospice	4b. City, Town, or Location of Death Baltimore		4c. County of Death	1
		Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 1 M 2 F 84 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye Mar 9, 19	9. Birth (Cou	nplace (State or Foreign untry) unk
		faryland show	ō	Usual Residence of Decedent				10d. Inside City Limits 1 Yes 2 □ No
		with the Na or 28e-1	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	
	920	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itams 23a or 28e-f show raumatic event, the Medical Examinat must be notified at	by Funeral	1 Never Married 2 Married 1 Yes 2 No	21201 Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2♥ No Specify:	pecify Yes or No- Rican, etc.)	USA  14. Race - Amer Black, White	, etc.
	Maryland 21215-0036	ithin 72 hou Je. Jan "natura e Medical S	Completed	(Specify only highest grade completed) (Give	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ang unk 16b	. Kind of Business/li	ndustry unk
	and 21	d be filed wantal Hygier (ed other to cevent, to	Be	unk   unk   17. Father's Name (First, Middle, Last)	unk 18. Mother's Nam	e (First, Middle, Maid	den Sumame)	unk
١	Baltimore, Maryl	iges 1 and it of Health If Item 27 or other ti	To	Joseph Richey Hospice 828  20a. Method of Disposition 20b. Place of Disp	ing Address (Street and Number or Rur  Eutaw Street Balt  costion (Name of smaller)	imore, MD	ity or Town, State, Zi  21201  c. Location - City or T	
12/4	Baltir	permit. Pa Departmer Important any injury once.		21. Signature of Funeral Service Licensee  Ronald S. Weder, Director S. B.	22. Name and Address of Facility tate Anatomy Board altimore, MD 21201	1 655 W. B	altimore	Street
5		Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Left middle certe  Due to (or as a consequence of):	nter the mode of dying, such as cardiac			Approximate Interval Between Onget and Death
4/1/06	8760,	eath certificate be executed settending physicien and mind for use as the bunal-transit	Ilcai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):				
alm	O. Box 68	0 0	Physician/Med		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	very Day Year
fry	rds, P	law requires that the as been signed by th 2 should be detache	ğ	Part II. Other significant conditions contributing to death but not resulting in the a	underlying cause given in Part I.		co use contribute to	\ /
L Du	Il Record	2 5 3	Completed			24a. Was an autopsy performed	prior to co	oppy findings available ompletion of cause of
Hymen	ion of Vital	ing Phy Mer this uneral c	To Be	25. Was case referred to medical examiner?  1	ent 3 DOA Other: 4 Nursing Ho	th Check only one one 5 Residence 28d. Describe how i		m) Haspice
K	Division	To the Hospitel or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fi	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rui tate)	ral Route Number,
		To the Hospitel or within 24 hours after To the Funeral Dirtompletely filled in 1	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal physician: To the basis of examination and/or in and manner stated.	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
		with To t	M	29b. Signature and fittle of certifier  (M)	29c. License number	29d.	Date signed (Month)	2006
•	_			30. Name and address of persen who completed cause of death (Item 23a) (Type	aton Ave Bo	e/Imore	MD.	21229
	17	Sta Registi		31. Date filed (Month, Day, Year)  APR 1 0 2006  33 Registrar's Signature	ede	-		-

		•	For State Registrar	State o	f Maryland		artment of H	Mental Hygiene			1036	
	E.		Decedent's Name (First, Middle, L.	ast)					2. Date of Deat Month	h Day	Year	3. Time of Death
н	Physici	_	Alexandros	Kall	inikidis	S			April	_ ′	2006	10:30 AM
	/Medic Examin	-	4a. Facility Name (If not institution, g	ive street and nu	mber)		4b. City, Town, or	Location of Death	1	_	ty of Death	
			710 E. Sem	inary	Avenue	_	Tow			Ba	c ltin	1000
7	Funeral			Sex	7. Age (In yrs. la:		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	lace (State or Foreign
	Director		unknown	1 <b>∑</b> (M 2□ F	92	Yrs.			March 5,	1914		eece
11757	p		Usual Residence of Decedent		10a City	Town or Lo	ention				1	0d. Inside City Limits
	aryla	ايا	10a. State 10b. County		Toc. Oity,							1 ☐ Yes 2 No
	Ba-f	cto		imore_		10	wson			0	(111)	
	ith th	Dire	10e. Street and Number	Λ.			10f. Zip Code	~ (	11	ug. Citizen o	f What Coun	uyr
	n 72 hours after death with the Maryland "natural", or iteme 23a or 28a-f show odical Examinatings be notified at	Funeral Director	710 E. Semina					-86			ace - Americ	an Indian
	er de	nue	11. Marital Status	Armed Fo		. 13.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puert	o Rican, etc.)		lack, White,	
36	s afte	by F	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Gi Year or D	ve		1□Yes 2XNo	Specify:		Spec	ify: Wh	ilte
215-0036	hour	pe	15. Decedent's		103.	16a Dece	dent's Usual Occupa	ation		16b. Kind of	Business/Inc	dustry
5	c * @	Completed	(Specify only highest	rade completed)		(Giva	kind of work done of DO NOT use retired	turina most of wor				,
212	within ene. then "	Ĕ	Elementary/Secondary (0-12)	College (	1-4or 5+)	F	Bus Driv	er	-	Trans	perto	ition
	should be filed withir Mental Hygiene. marked other than imatic event, Ins.M.		17. Father's Name (First, Middle, La	st)	<u></u>			18. Mother's Nar	ne (First, Middle, M	Aaiden Sum	ame)	
an	ould be Mental arked o	To Be	Lazaros Ko	elliniki	dis			Maci	a Un	Knou	10	
Maryland	2 should and Men is marke sumatic	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ng Address (Street a	and Number or Ru	iral Route Number	City or Tow	m, State, Zip	Code)
M	~ ~ = =		Sia Mamunes	1 Daug	hter	1101	Dulaney	Gate C	ircle Co	ckeys	ville,	MD 21030
ē,	Health tem 27 other tr		20a. Method of Disposition		20b. Pla	ace of Dispe	osition (Name of matory or other place	<b>a</b> )			n - City or To	
Baltimore	permit. Pages 1 a Department of Hes Important: if item any injury or othe once.		1 ☐ Burial 2 ☐ Cremation 3 4. ⑤ Conation 5 ☐ Other (Spe		State I.		fts Regist	1.4	3,2006	Hano	ver,	MD
Ħ	permit. Pag Department Important: I any injury c		21. Signature of Funeral Service Lic	The state of the s	7	2	2. Name and Addres	s of Facility A	tomu Gifts	Registre	1 0	
Ba	Depa Impo any i		1 6 -	+		140		7522	er MD 2	1076	the P.	
		-	23a. Part1. Enter the disease, or or	mplications that	caused the death.	Do not en	ter the mode of dyin		The state of the s			Approximate Interval Between
			shock, or heart failure. List or Immediate Cause (Final	ty one cause on	1	2 2	1: 0	7	1/200	f	- 1	Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	Inche a conseque	ence of):	dias	- IM	Kazci		-	
1	Examiner			20010	1110	07	Jan.	PURP				
	* <u>*</u>	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	b. Due to	(or as a conseque	ence of):	7					
	uted i insit	듄	cause. Enter Underlying Cause (Disease or injury that initiated events				,				1	
Ć,	be executician and burial-tran	Examiner	resulting in death) Last	Due to	(or as a conseque	ence of):						
760,	e be /sicia e bur	edicai	N.	d								
89	certificate Iding physise as the	edi										
Вох	eath certificate be executed attending physician and for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pregnan		Ectopic pregnancy				Date of delive	
	death e atter ed for u	cia	in the past 12 months?		nant at time of dea		Other (specify)			'	Month	Day Year
P.0	that the de ed by the detached	hys	9 Unknown	9LI ONKI	IOWII			- ALAS				
	requires that the een signed by th nould be detache		Part II. Other significant condition	s contributing to d	leath but not resul	Iting in the t	underlying cause giv	en in Part I.				he cause of death?
rg	v require been sig should b	Pa	#157074	0/ >1	uma	04	cance	<u> </u>	1 🗆 Ye	s 2 ANO	3 Prot	oably 4 □Unknown
SC	2 20 10	piet	/	/					24a. Was a	iV.	b. Were auto	opsy findings available impletion of cause of
Ä	The law	Completed by		,					perform	ned?	death?	
ta	ucian: Th certificate rector, pag	O	25. Was case referred to medical					26. Place of De	ath Check only	ak.		
>	Physician: this certific ral director,	To B	examiner? 1 Tes 2 No	Hospital:	Inpatient 2 🗆 E	R/Outpatie	nt 3 DOA Oth	er: 4 🗌 Nursing H	lome 5 Reside	ence 6 🗆 C	Other (Specif	у)
0		ë	27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o	of 28c. Injur	y at k?	28d. Describe ho	w injury occ	curred	
Ö	Attending r death.	atio	1 Natural 5 Pending 2 Accident investiga	tion	,,,	,,		Yes 2 □ No				
Division of Vital Records,	Atte	Certification:	3 Suicide 6 Could no 4 Homicide determin	289. Plac	e of Injury - At hor ling, etc. (Specify)	me, farm, st	treet, factory, office		28f. Location (St City or Town	treet and Nu. n, State)	mber or Rura	il Route Number,
Ö	saft saft ai Dii	Cer			, , ,							
	hour hour uner	ca	29a. Certifier 1 Certifying	Physicien: To the	e best of my know	vledge, dea	th occurred at the tir	ne, date and place	e, and due to the curred at the time. d	ause(s) and	manner as s	tated. o the cause(s)
	he H in 24 ihe F plete	edicai	one)	and mai	ner stated.							
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Σ	29b. Signature and title of certifier	1	~ "I	1 D.	29c. Licens			1	ned (Month,	
	n		1 / Xto	4/100	/ N		1	2617	8 1	MIL	0,	2006
	X		30. Name and address of person w	pompleted cau	se of death (Item	23a) (Type	Print)	ck mi	COOV A	7	-	2006 1 Md 212
			GEORGE 1	IKPI		M.D	NO E.	se mil	YKX 4	re 10	WJOY	11/19 212
91		ate	31. Date filed (Month, Day, Year)	32	Registrar's Signati	ure	all I					
1	Regist	24	APR 1 0 20	05	MAN ST	Park						
DH	MH 17 Rev 1/2	2001	-	Con.		-						

DHMH 17 Rev 1/2001

		_	For State Registrar		of Marylan		artment o				Reg. No	IIIIh	State of the last	137
п	Physici	an	Decedent's Name (First, Midd			17 - 11 -	-21			2. Date of De	Da		3. Time	of Death  A  M
	/Medic	al -	Mary  4a. Facility Name (If not institution	Helen	ımhar)	Kelle	4b. City, Tov	um or Locati	ion of Deat	April :		006 County of Deat	)//	
	Examin	er	515 Academy		iniber)			nsvil				Baltimor		
	Funeral	-	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y	ear If Un	der 24 Hrs		th	9. Birt	hplace (State	e or Foreign
	Director		214-26-7785	1□M 2K□F	93	Yrs.	Months D	ays Hou	rs Min.	Nov. 2	0, Year)	912 Penr	untry) isylva	nia
	p ,		Usual Residence of Decedent		10. 0	v. Town or Lo					-		404 114	01-11-1-
	deeth with the Maryland me 23a or 28a-f ehow rnwet be notified at	7	10a. State 10b. Count			, .							10d. Inside	es 2 No
	ours after deeth with the Maryla ef', or Iteme 23a or 28a-f ehov Examinet must be rectified at	Funeral Director	Maryland Balti 10e. Street and Number	imore		Catons					10- 04	of 14th-1 O-		
	with a or	급		and			10f. Zip Co	1228			_	izen of What Co JSA	untry?	
	eeth	erai	515 Academy Ro		edent Ever in U.	S. 13.			Origin? (5	Specify Yes or No		14. Race - Ame	rican Indian	
10		E	1 ☐ Never Married 2 ☐ Ma	Armed Fe	orces?				cican, Puer	Specify Yes or No to Rican, etc.)		Black, White	e, etc.	
38	urs aff	by	3 Widowed 4 □ Divorce	ed If Yes, Gi	ive Dates:		1 ☐ Yes 2 🔀	No Spec	city:		}	Specity: V	Mite	
Baltimore, Maryland 21215-0036	filed within 72 hours after Hygiene. Ither then "naturel", or Ite ont, the Medical Examine	Be Completed		ent's Education rest grade completed)		16a. Dece	dent's Usual O	ccupation	most of wo	deina	16b. K	ind of Business/	Industry	
2	thin 69.	pie	Elementary/Secondary (0-12)		1-4or 5+)	life.	DO NOT use r	etired)	11031 01 110	ikiig				
2	ed wi	Sol	12				Sales					partment	Stor	e
P	be fill H d off	Be	17. Father's Name (First, Middle	a, Last)	37 1			18. M		me (First, Middle			. L	
<u>~</u>	should be nd Mental marked o	ျှ	John		Yereb				Ther			ryuravio		
Mar	12 sh h and 7 le m		19a. Informant's Name/Relation							ural Route Numb			Zip Code)	
a)	1 and Heelt am 2 ther 1		Marie T. Gilla 20a. Method of Disposition	in (Daught			Academ sition (Name of		, Cat	onsville Date		0 21228 ocation - City or	Toum State	
آو	ages nt of h		1 € Burial 2 Cremation		State St.	emetery, cred Mary	Our Mo Ceme	ther	4/7/					. 1
Ę	it. Partimer ritmer ritent njury		4 Donation 5 Other (			7	Ceme	tery		oudon Pa	Hors	seheads,	New	York
Ba	permit. Pages 1 and 2 should be filed within 72 ho Depertment of Heelth and Mental Hygiene. Important: If Itam 27 ie marked other than "naturent plury or other traumatic event, the Medical ony Injury or other traumatic event, the Medical ODGE.		21. Signature of Fulleral Service	e CICHISOO						, Balti				
			23a. Part1 Enter the disease, of	or complications that	caused the deatl								Approxin	nate
			sheek, or heart failure. Lis Immediate Cause (Final	st only one cause on	each line.			_		o or roopmatory t	.,,		Interval E Onset ar	Between
	Physician /Medical		disease or condition resulting in death)	a	(or as a consequence	/	ENUS	13					424	25-
	Examiner			D00 (0	(or as a consequ	derice or).								
	*	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to	(or as a conseq	uence ol):								<u> </u>
1/2	onted ansit	Examiner	Cause (Disease or injury that initiated events	1.										
0,	cate be executed obysiclen and the burial-transit	Ex	resulting in death) Last	Due to	(or as a conseq	uence of):								
8760,	ate be	dicai		d										
9	n certifica anding ph use as tl	Med	IF FEMALE:											
Вох	eath certif attending for use as	an/	23b. Was decedent pregnant in the past 12 months?		atcome of pregna birth 2 ☐ Feta		Ectopic pregr	nancy				23d. Date of del Month	ivery Day	Year
	Attending Physician: The law requires that the death certific roleath. ector: After this certificate hes been signed by the attending p by the funeral director, page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 € No 9 ☐ Unknown	4□Preg 9□Unkr	nant at time of di nown	eath 5[	Other (specif	ý)				WORUT	Day	1001
P.0	that the de ed by the detached		Part II. Other significant condit	tions contributing to	death but not ree	ulting in the u	n doshina sauc	o awas is B	art I	23a Did	tobacco	use contribute to	the cause (	of doath?
Division of Vital Records,	signed to be det	b b	ATRIAL 1		ATTEN	uning in the c	inderlying cads	o giveirii i	aiti.		Yes 2		obably 4	
Š	w requir been si should	ete	14,050	5 8 7	TINA									
360	hes hes	Completed	1/4/1/6/2	rice	0					24a. Was		24b. Were au prior to death?	completion of	ds available cause of
a	ılcian: Th certificata rector, pag		1/VLTI-TA	FARET	REHER	TAN				1 ☐ Yes	2 € No		2□ No	
Ζ	ding Physician: The h. A. Atter this certificate he funeral director, page	Be	25. Was case referred to medic examiner?	Hospital:				Othor		ath (Check only				
of	Phys r this ral di	- To	1 ☐ Yes 2 ☐ No 27. Manner ol Death	10	Inpatient 2 of Injury	28b. Time o			] Nursing I	dome 5. Res			ci <b>fy</b> )	
0	ding F th. : After funer	lior	1 ♠Natural 5 ☐ Pend 2 ☐ Accident inves	ding (Mor stigation	nth, Day Year)	Injury	М	Injury at Work?	2 □ No			,		
/İSİ	Attendir death.	Certification:	3 ☐ Suicide 6 ☐ Could	Id not be 28e. Plac	e of Injury - At he	ome, farm, st	reet, lactory, of	fice		281 Location	Street ar	nd Number or Ri	ıral Route N	umber,
ă	afor Dire	ert	4 Homicide	build	ding, etc. (Specif	y)				City or To	wn, State	e)		
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the		29a. Certifier 12 Certify	ying Physician: To th	e best of my kno	wledge, deat	h occurred at t	he time, date	e and plac	e, and due to the	cause(s	) and manner as	stated.	
	he Ho in 24 he Fu	edical	(Check only 2 Medics one)	al Examiner: On the tand man	basis of examina nner stated.	tion and/or in	vestigation, in	my opinion,	death occ	urred at the time	, date an	d place, and due	to the caus	e(s)
	To t To t	Σ	29b. Signature and title of certif	fier /	^		29c. L	cense numb	ber		29d. Da	signed (Mont	h, Day, Year	)
	4.		tent	Fale, MI	<i>()-</i>		DI	999/			.4/	3/200/	6	
_	10		30. Name and address of perso	on who completed cau	ise of death (Item	1 23а) (Туре,	Print)	•0		- 0	/	L.		
	\	4	PAUSO RESE, M.D.	- Surge	4/2 20	U Hes	PATAC	Ins	r O	Es Bi	yes	is Thy	ALD	2106/
i i	Sta	_	31. Date liled (Month, Day, Yea APR 1 0	2006	Registrar's Signa	ture								
- 1	Registi	aı	11.11.7	A.	_	-								

			State of Maryland / Department of Health and I  State Registrar  Certificate of Death	-	giene Reg. No. 0	6 11038
	Physic		1. Decedent's Name (First, Middle, Last) Allan S. Kinsey, Jr.	2. Date of De April	_	3. Time of Death 10:10 a M
3	/Medi Exami		4a. Facility Name (If not institution, give street and number) Atlantic General Hospital  4b. City, Town, or Location of Death Berlin			of Death Cester
193	Funeral Director		5. Social Security Number 219-12-5608  6. Sex 1 \overline{\text{N}} \text{M} 2 \overline{\text{F}} F  7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.    Usual Residence of Decedent		, 1913	Birthplace (State or Foreign Country)     Maryland
5	aryland •how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
7	e Man	ctor	MD Worcester Berlin			1 ☐ Yes 2 No
5	death with the Maryland ms 23a or 28e-f ehow must be notified at	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of W	
0	ns 23a	Funerai	304 Ann Drive 21811  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	Specify Yes or No	U.S.,	- American Indian,
00	6 after of after of miner	Fun	11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in U.S.  Armed Forces?  143 - 165  147es, Specify Cuban, Mexican, Puerlift Yes, Give  1 Yes, Give  1 Yes, Give	to Rican, etc.)		, White, etc.
$\bigcap$	003	d by	3 △ Widowed 4 □ Divorced Year or Dates:		Specify:	MILL CC
	in 72 in 72	Completed	15. Decedent's Education (Specify only highest grade completed)  (Give kind of work done during most of work life, DO NOT use retired)	rking	16b. Kind of Bus	aness/Industry
300	212	mo;	Elementary/Secondary (0-12) College (1-4or 5+) 5+ School Teacher		Educat	ion
00	Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mantal Hygiene. Important: If item 27 is merked other than "natural", or items 23a or 28e-1 ehov any injury or other traumatic event, it a Medical Exertinal must be notified at once.	Be	011 5 12:		Maiden Sumame nette	9) Smith
2	should nd Mei mark imatic	2	AIIAN 5. KINSEY, 5r. Laura  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru			
1	Malth ar alth ar trau		Allan S. Kinsey, III–son 304 Ann Dr., Berlin,		B11	
N	altimore, mit. Pages 1 ar pertment of Hea portent: If item y injury or other Ca.		20a. Method of Disposition  1 XBurial 2 Cremation 3 Removal from State	Date		City or Town, State
1	Itiment ritant:		4 Donation 5 Other (Specify) Garrison For. Vet 4/13  21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Rug		:OwingsM :Dungs	
0	Dan permi Depe impo any ii		1050 York Rd., To			r nome, inc.
N	· · · · · · · · · · · · · · · · · · ·		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. ACute myo candol Inforch	M		Two days
	Examiner		Due to (or as a consequence of):  (a) NCERN CE HELLA AMERICA			6 montes
	olp =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	·		6. 4
5	ecute and F-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):			Onon
2	18760, Tacate be executed physicien and the burial-transit	dicai E	355 6 (6) 454 651 654 651 65			
F	687 tificate ig phy: as the	ledic	<b>~</b> 0.			
	Box 6 eath certifi attending for use as	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy		23d. Date Mon	of delivery th Day Year
3	O e e e e	Completed by Physician/Me	1   Pres 2   No 9   Unknown   5   Other (specify)		Wildin	ar bay roar
5	ds, P.	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contri	bute to the cause of death?
5	cords, v requires been sign should be	ted t	None	1 🗆 '	Yes 2□No	3 ☐ Probably 4 DUnknown
1	Records he law requires e has been sign	npie		24a. Was autor	osy pi	lere autopsy findings available rior to completion of cause of
	Vital Fincian: The certificate rector, pag			1 Yes	2 No 1	eath? □ Yes 20 No
	Division of Vital Re tor Attending Physician: The effer death. Director: After this certificate he in by the funeral director, page	To Be	examiner?	ath <i>(Check only c</i> Horne 5 □ Resi	one) dence 6 □Oth <i>e</i>	r (Specify)
	n of Physical ther this meral di		27. Manner of Death 1 Death 28a. Date of Injury 28b. Time of Injury at Work?		how injury occurre	
	Attendii death. ctor: A y the fu	icati	2 Accident investigation M 1 Yes 2 No	206 Leasting (	Chandaland	Dest Contact State
	Division of the notation of the death in Director.	Certification;	determined  determined  determined  determined  determined  determined  determined  determined  determined  determined  determined	City or To		r or Rural Route Number,
	Division of To the Hospital or Atlanding Ph within 24 hours effer death. To the Funerel Director: Affer th completely filled in by the funeral	Medicai C	29a. Certifier (Check only one)  1. Cartifying Physician: 1: the best of my kin wladge death occurred at the time date and place 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the urred at the time,	date and place, a	nar ac stated nd due to the cause(s)
_	To the within 2 To the comple	Me	29b. Signature and title of certifier 29c. License number		- /	(Month, Day, Year)
			D00508	826	4/1	H06
_	6+1		30. Name and a riess of person who completed cause of death (Item 23a) (Type, Print)  Nor work Contola 9733 Healthway D	180 1	7,	811
	St.	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	BY	1-1	DII
	Regist		APR 1 0 2006 delever to be seen			

		1	For S State Registrer	tate of Maryland	d / Depa <i>Cer</i>	rtment <i>tificate</i>	of He	ealth a Death	nd Menta		ene 006	11039
	Physician	n	. Decedent's Name (First, Middle, Last)	mp						onth 7,	<sup>0</sup> 2006 Yea	3. Time of Death 11:48р м
	/Medica Examine		a. Facility Name (If not institution, give stre Gilchrist	et and number)		4b. City, T Tows		Location of			4c. County of De Balti	more
	Funeral Director	5	Social Security Number 6. Sex 1 XM	2□F 7. Age (In yrs. In 79	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. 8. Da	te of Birth looth, Day, 1 11 y 31		lirthplace (State or Foreign Maryland
200	show		Usual Residence of Decedent  10a. State 10b. County  Md. Baltimore		, Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2X No
distriction of the state of the	a or 28a-	ੂ ਹੋ	Oe. Street and Number 20 Lambourne Rd. G-			10f. Zip 21	Code 204			109	g. Citizen of What	Country? SA
3 44 0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the wasy sat Department of Health and Mantal Hyglene. Important: it fame Z? is marked other than "natural; or iteme 23a or 28a-1 show any injury or other traumatic event, the Modical Examinat must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	Was Decedent Ever in U. Armed Forces? 1 _Yes _2X_No If Yes, Give Year or Dates:		Was Deced f Yes, spec		spanic Orig n, Mexican Specify:	gin? (Specify Y i, Puerto Rican	es or No- , etc.)	14. Race - A Black, W Specify:Wh	
215-	within 72 hourshes. than "natural is Medical E.	Completed	15. Decedent's Educal (Specify only highest grade of Elementary/Secondary (0·12)	ion		dent's Usua kind of woi DO NOT us minis	k done d e retired	during mosi )	t of working	11	Sb. Kind of Busine	·
N	d be filed a antal Hygie ced other cevent, II	To Be Co	17. Father's Name (First, Middle, Last) Paul E. Kemp						er's Name (Firs rgaret	Wanko	aiden Sumame)	
Mary	nd 2 should alth and Men 27 is marke r traumatic		19a. Informant's Name/Relationship (Type Eloise Kemp/ Wife	, Print)	19b. Mailii 20	ng Address Lambo	(Street a	Rd.	er or Rural Rou G-16 T	owson,	City or Town, Stat Md. 212	
4/7/0 Baltimore,	Pages 1 e ient of Hee nt: if item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)		Place of Dispo emetery, crea 11top	matory or o	ther plac		Date 4-11-06		Oc. Location - City	
4/ Baltii	Departm Departm Importa eny inju		21. Signature of Pun red Service Licensee	3					Funeral . Towso			
red	icate be executed by Medical Examiner and Examiner sthe purish-transit	Ical Examiner	23a. Part! Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)	Majuence of):	ter the mod	e of dyir	g, such as	cardiac or res	piratory arre	St.	Approximate Interval Between Onset and Death Mon Th S
. Box 687	death certif e ettending od for use a	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	c. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3	□Ectopic p		у			23d. Date o Month	delivery Day Year
ds, P.	gne d	by	Part II. Other significant conditions cont	nbuting to death but not res	sulting in the	underlying	cause gr	ven in Part	1.			te to the cause of death?  Probably 4 Minknown
人に Records,	The law requires thet the sete has been signed by the page 2 should be deteched	Completed								24a. Was a autops perform 1 Yes 2	y prio ned? dea	e autopsy findings available r to completion of cause of th? Yes 2010
$\rho_{AuL}$ Division of Vital	ng Physicien tter this certific neral director	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Ho  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	spital: 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	ER/Outpation 28b. Time Injury		28c. Inju Wo	her: 4 🗆 N		5 🗌 Reside		specify) HOSPICE
Divisi	To the Hospitel or Attendity within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At the building, etc. (Special	nome, farm, s ify)	street, facto	ry, office		28f.	Location (Si City or Town	treet and Number n, State)	or Rural Route Number,
	ne Hospite 24 hours ne Funere stetely fille	Medical (	29a. Certifier 1 Secretifying Physics (Check only one) 2 Medical Examin	or: On the best of my kn er: On the basis of examin and manner stated.	ation and/or	ath occurra investigatio	d at the t n, in my	ime, date a opinion, de	and place, and eath occurred a	at the time, d	ate and place, and	due to the cause(s)
	To the To the Comp	×	29b. Signature and title of certifier	el mo			100	ose number	99		April, 8	,2004
-	15		30. Name and address of person who con Jason Black	6607 1	om 23a) (Тур ОГП (	e, Print) Char	les	St,	Tous	np	10 212	-04
	Sta Regist		31. Date filed (Month, Pay, Year) APR 1 0 20	32. Begistrar's Sign	iature							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland		rtment of Heatificate of De		ental Hygien	2000	1040
	Physici	an	1. Decedent's Name (First, Middle, La	,			2	2. Date of Death Month	ay Year	3. Time of Death
V	/Medic			IR KEMU				04 03	2006	130 "
1	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or Lo			c. County of Dear	
				SHOSPITAL	6 :- 6 A	If Under 1 Year   If	Under 24 Hrs.		10N7G0	
	Funeral Director		5. Social Security Number 6. S	Sex 7. Age (In yrs. last	Yrs.		lours Min.	B. Date of Birth Month, Day, Yea	r)   Co	hplace (State or Foreign
			Usual Residence of Decedent				1 25	04 032	006 MA	IRYLAND
	ylend wow		10a. State 10b. County	10c. City, To	own or Lo	cation				10d. Inside City Limits
	Mar	ţ	MEM MONTO	OMERY SIL	UE	2 SPRIN	)( <sub>0</sub>			1 XYes 2 No
	or 28	Director	10e. Street and Number	4		10f. Zip Code		10g. C	itizen of What Co	ountry?
	th will	aiD	MIS & UNIVE	RSITY BLVD # ?	5	2090	03	U	SA	
	ans ams	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		Vas Decedent of Hispa Yes, specify Cuban, I	anic Origin? (Spec Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - Ame Black, Whit	
9	or it	F.	1 Never Married 2 Married	1 Tes 2 No If Yes, Give Year or Dates:		☐Yes 2MNo S			Specify: 3	
ë	within 72 hours after death with the Marylend ene. Than "natural", or itams 23e or 28e-f ehow Ita Medical Exercites most be notified at	d by	3 Widowed 4 Divorced							
7	n 72	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give	ent's Usual Occupatio kind of work done duri OO NOT use retired)	n ng most of working	160.	Kind of Business	Industry
2	within them	E C	Elementary/Secondary (0-12) none	College (1-4or 5+)	none	,			none	
D	Hygid Other	Be C	17. Father's Name (First, Middle, Last		HOH		. Mother's Name (	First, Middle, Maide		
a	lid be lental ked c	To B	ALIMAMY	LIMEN			AMINI	A BAN	AI GILD DI	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylen and Mental hygiene is and Mental hygiene is merked on the table is merked on the table is merked on the mental cancellate in the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examination in the medical Examination is a conflict of the medical Examinatio		19a. Informant's Name/Relationship		9b. Mailin	g Address (Street and				
	D = D =		HOLY CROSS	HOSPITAL 1	200	FOREST C	LEN RD	SILVER	SPRING	MD 20910
ore C	of He of He roth		20a. Method of Disposition 1 Burial 2 Cremation 3	come	of Dispos	sition (Name of natory or other place)	Da	te 20c.	Location - City or	Town, State
Ĕ	Pages nent of ant: If Its ury or o		4 □Donation 5 🖾 Other (Speci							
Baltimore,	permit. Pages 1 an Depertment of Heal Important: if Itam 2 any injury or other once.		21. Signature of Luneral Stryice Lice Non and S.	Wade Director	St Ba	Name and Address of ate Anaton ltimore, M	r Facility Dig Board D 21201	655 W. Ba	ltimore	Street
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the death. D	o not ente	er the mode of dying, s	uch as cardiac or	respiratory arrest,		Approximate Interval Between
1	Physician		Immediate Cause (Finat disease or condition	a_RUPTURE	M	ARRING.	NEC		-	Onset and Death
<i>A</i>	/Medical		resulting in death)	Due to (or as a consequence		,	14 6 5			
	Examiner		Sequentially list conditions.	D. PREVIABL	E 3	DELIVER	P			
	sit ad	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury	Due to (or as a consequent	ce of):					
_	and and I-tran	Examiner	that initiated events resulting in death) Last	c	e of):					
8760,	cate be executed physicien and the burial-transit	dical E								
687	The law requires that the death certificate be executed tie has been signed by the ettending physicien and bege 2 should be detached for use as the burial-transit	edic		G						
Вох	leath certific ettending pl	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy		-			23d. Date of dei	ivery
œ.	death e ette	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal dea		Ectopic pregnancy Other (specify)			Month	Day Year
Р. О	at the by th	hys	9 Unknown	9□ Unknown				I		
ś	res that the de signed by the e be detached f	by	Part II. Other significant conditions	contributing to death but not resulting	g in the un	derlying cause given i	n Part I.			the cause of death?
ord D	w require been signal	ted						1 Tes	2MQNo 3∏Pr	obably 4 Unknown
Ö	law law las bo	Completed						24a. Was an autopsy	24b. Were at	stopsy findings available completion of cause of
=		S						performed? 1 ☐ Yes 2 🗷 N	death?	
VIE S	ilcian: Th certificete rector, peg	Be	25. Was case referred to medical examiner?	Hospitali		1.00	6. Place of Death (			
o	Physician: this certifice ral director, p	5	1 Yes 2 No  27. Manner of Death		Outpatient  o. Time of			5 Residence		cify)
L <sub>O</sub>	ding h. After fune	ē	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	28c. Injury at Work? M 1 ☐ Yes	2 No	d. Describe how in	ury occurred	
Division of Vital Records,	or Attendi after death. Diractor: A in by the fu	fical	3 Suicide 6 Could not b	e con Blace of Injury At home	tarm stre			f. Location (Street a	and Number or Ri	ural Route Number
2	after Direction of the big	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	varin, stre	ot, factory, office		City or Town, Sta		nar riodio rvaribor,
	To the Hospital or At within 24 hours after of To the Funeral Dirac completely filled in by	edical C	29a. Certifier 1 Certifying P	vsician. To the best of my knowled	tge, death and/or inv	occurred at the time, estigation, in my opinio	date and place, an	d due to the cause( at the time, date a	s) and manner as nd place, and due	stated. to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and mariller stated.		29c. License nu	umber	29d. D	ate signed (Mont	h, Dey, Year)
	⊢s⊢ő		· I UL	$\sim$		DHH.	797	Uri	102/	001-
			30. Name and address of person who	completed cause of death (Item 23)	a) (Type, I	Print)	( )	10-1	103/2	000
			DR DARRYN	BAND 10313		ORGIA P	FUE SIN	YER ST	RING	KOPOS CM
	Sta	_	31. Date filed (Month, Day, Year)	32 Registrar's Signature						
	Registr	ar	APR 1 0 2	106 Marines 18	A CONTRACTOR OF THE PARTY OF TH					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#5, perFI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month AM **Physician** 2006 Apri Khana /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE Randallstown Center Northwest HOSPITA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. AUG. 20, 1922 9. Birthplace (State or Foreign Country) UKRAINE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 018-80-17002 1 ☐ M 2 ☐ F 83 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No OWINGS MILLS Director BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 104 PLEASANT RIDGE DRIVE #206 21117 or Items 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. International Items 27 is marked other than "natural", or Itam any injury or other traumain. Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No WHITE If Yes, Give X Year or Dates: Specify Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ACCOUNTING ACCOUNTANT 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (UNKNOWN) URIK SONYA ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 19a. Informant's Name/Relationship (Type, Print) 104 PLEASANT RIDGE DRIVE #206 - OWINGS MILLS, MD IOSIF KHALFIN / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP 04/07/2006 TOWSON, MD 1 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician . Multiple organ system /Medical resulting in death) Due to (or as a consequence of): Examiner Myocardia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): burial-transit atheroscleratic vaseular disease The law requires that the death certificate be executed Generalized and resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Month Day Year be detached for 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown response ammator 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Alzheimer dementie 24a. Was an autopsy performed? Yes 2 ld No page 2: certificate 1 Yes ector, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Other: 1 ☐ Yes 2 ☑ No Hospital: 1 V Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral! 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death 28b. Time of Certification: or Attending 1 Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainteness of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier D24682 April 6,2006 Koolons M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstown, Maryland Center Northwest Hospita Boston MD 32. Registar's Signature 31. Date filed (Month, Day, Year) State 0 2006 Registrar

			1- State O State O	f Maryland		artment of tificate of		Mental Hyg	iene	6	1042
	Physici /Medic		1. Decedent's Name (First, Middle, Last) R0*2A	KUN	YA	VSKA	/A	2. Date of Deal Month APML	Day	Year	3. Time of Death 7:05 A M
)	Examin Funeral		4a. Facility Name (If not institution, give street and number 1.5. Social Security Number 1.7. 1.1.0.1	7. Age (In yrs. Ia		4b. City, Town  R  If Under 1 Yea  Months Days		5 WN 8. Date of Birth		LTIM	ce (State or Foreign
	Director	or	217-45-1191   1   M 2   X   F   Usual Residence of Decedent  10a. State   10b. County  MD   BALTIMORE		Yrs. Town or Lo	cation		JUN.9,1	.923		d. Inside City Limits  1 □ Yes 2 🌣 No
	3a or 28e-	i Director	10e. Street and Number 7920 SCOTTS LEVEL ROAD			10f. Zip Code	21208	1	0g. Citizen of W	/hat Countr	y? RUSSIA
36	within 72 hours after death with the Maryland ene. then "neturel", or items 23s or 28e-f ehow the Medical Examiner must be notified at	by Funerai	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  1 Yes If Yes, Given Year or Divorced	2.0XiNo ∕e	1	Vas Decedent of f Yes, specify Cu l □ Yes 2 No		Specify Yes or No- to Rican, etc.)		- America k, White, et	
Maryland 21215-0036	i within 72 hou jene. r then "nature the Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  4 College (1	-4or 5+)	(Give	00 NOT use retir	e during most of wo	orking	16b. Kind of Bu		MUSIC
/land ?	should be filed ind Mental Hygis marked other umatic event, It	To Be C	17. Father's Name (First, Middle, Last) YOSEF		GINS	BURG	18. Mother's Na BERT	me (First, Middle, M HA	Maiden Sumame		(NOWN)
_	d 2 th a tra	1 1000	19a. Informant's Name/Relationship (Type, Print)  ALLIE FAYVUSOVICH / DAU  20a. Method of Disposition  1 ☼ Burial 2 □ Cremation 3 □ Removal from	0.0	144 W	-	STNUT HIL		-	STOWN	, MD 21136
Baltimore,	permit. Pages 1 an Depertment of Heal Important: If Item 2 any injury or other once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	BAL	22	HEBREW Name and Add	ress of Facility S	07/2006 OL LEVINS ROAD - F		ROS.,	
8760,	The law requires that the death certificate be executed with the death certificate be executed with the bear signed by the attending physician and barrier and be detached for use as the burrial-transit uses.	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ach line.	ence of):			c or respiratory arre		1	Approximate Interval Between Onset and Death
O. Box 6	that the death certific ed by the attending f detached for use as	by Physiclan/Me	in the past 12 menths?	come of pregnan irth 2 Fetal o ant at time of dea own	déath 3□	Ectopic pregnan Other (specify)	су		23d. Date Mon	e of deliver	/ Year
Records, P.O	w requires that to been signed by should be detail		Part II. Other significant conditions contributing to de	eath but not resul	lting in the ur	nderlying cause g	iven in Part I.			ibute to the	cause of death?
Vital Rec	yelcian: The law is certificete hes b director, page 2 st	• Completed	25. Was case referred to medical				90 80 100		y ned d 2 1 No 1	rior to comi eath?	sy findings available pletion of cause of
Division of Vil	To the Hospitel or Attending Phyeicien: within 24 hours efter death. To the Funeral Director: After this certifice completely filled in by the funeral director, to	atlon: To Be	examiner?    Yes 2 DNo		R/Outpatien 28b. Time of Injury	28c. Inj	ther: 4 \sum Nursing	ath (Check only on Home 5 Reside 28d. Describe ho	nce 6 □Othe		
DIVIS	To the Hospitel or Attending Ph within 24 hours eiter death. To the Funeral Director: After th completely filled in by the funeral	Certification	4 Homicide Striming buildi	of Injury - At horng, etc. (Specify)				28f. Location (St City or Town	n, State)		
	o the Hosp ithin 24 ho o the Fune ompletely fi	Medical	29a. Certifier (Check only one)  1  Certifying Physician: To the beautiful and the	best of my know asis of examination for stated.	rledge, death on and/or inv	estigation, in my	time, date and place opinion, death occurrence	urred at the time, da	ause(s) and mar ate and place, a 9d. Date signed	nd due to t	he cause(s)
	⊢ ≯ ⊨ ŏ		30. Name and address of person who completed caus	o Hen	MD		13481	1	-		2006
	Sta Registr		MILLIAEL ROT	HHV Sistrar's Signatu	5401		COURT RU	040 RA	MAUS	TOWN	MARYLAND 21133

			for State Registrer	State of	Maryland		artment o				giene Reg. No.	006	10	43
	Physici	an	1. Decedent's Name (First, Middle Dawn Marie							2. Date of De. March	ath 3 <sup>Day</sup>	2006	3. Time of 9:00	Death P M
1	/Medic		4a. Facility Name (If not institution		ber)		4b. City, Tow	m, or Location		naren		unty of Death	7.00	
			215 Patapsco				Dund		- 04 11			timore		
	Funeral Director		5. Social Security Number 219-90-2296	6. Sex 1 □ M 2 ☑ F	7. Age (In yrs. las	Yrs.	If Under 1 You Months Da	ear if Unde	or 24 Hrs. Min.	8. Date of Bin (Month, Da 1 – 22 –	y, Year) 67	9. Birth Cou MD	place (State o	r Foreign
	yland		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation						10d. fnside Cit	ty Limits
	Sa-1 st	ector	MD		Dui	ndalk							1 🗌 Yes	2 No No
	th with the 23a or 2	Funeral Director	10e. Street and Number 215 Patapsco	Ave.			10f. Zip Coo 21	222				of What Cou S . A .	ntry?	
920	in 72 hours after death with the Maryland "natural", or Itsma 23a or 28a-1 show rdical Examiner must be notified at	þ	11. Marital Status  1 □ Never Married 2 ☑ Marri 3 □ Widowed 4 □ Divorced	Armed Ford	XXNo		Was Decedent f Yes, specify (			ecify Yes or No Rican, etc.)		Race - Ameri Black, White, White ecify:	etc.	
21215-0036		Completed	15. Decedent (Specify only highes Etementary/Secondary (0-12)	s Education t grade completed)  College (1-	4or 5+)	16a. Deced (Give life. I	lent's Usuat Od kind of work do DO NOT use re	ccupation one during mo etired)	ost of work	ing	16b. Kind	of Business/In	dustry	
	filed within Hygiene. Ither then "		9th		401 34)	Cas	hier	40.14-4	- 1 Ni	(57: ) 14:14		t Food	<u></u>	
land	e d a b	To Be	17. Father's Name (First, Middle, I James Wilson	.ast)						e (First, Middle, ilson	Maiden Su	mame)		
Maryland	nd 2 shullth and 27 is m		19a. Informant's Name/Relationsh Newton Kelly	ip (Type, Print) , Jr. (Hu	sband)	19b. Maifir 212	g Address (Sti Patap	reet and Num. SCO A	ber or Rura Ve .	al Route Numbe Dundal	er, City or To	21222	Code)	
Baltimore,	000==		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 □Removal from S	20b. Pla	ce of Dispo netery, cren Lawr	sition (Name of matory or other Ceme	tery	4-5-	Date 06		ion - City or To alk, MI		
Balti	permit. Pag Depertment Important: any injury o		21. Signature of Funeral Service I	icensee Man	the state of					sley C . Balt				
4	death certificate be executed  Exam  Medical by scien and certificate as the burial-transit  of for use as the burial-transit	Icai Examiner	23a. Part 1. Enter the disease of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	r as a conseque	nce of):	rui			/	rest,		Approximate Interval Betv Onset and D	ween
Box 6	that the death certifica led by the attanding ph detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		th 2 ☐ Fetal d nt at time of dea	eath 3	Ectopic pregna				23d	Date of delive	•	'ear
Δ.	quires that n signed build be deta	þ	Part II. Other significant condition	ns contributing to dea	ath but not result	ing in the ur	nderlying cause	egiven in Par	11.		obacco use	contribute to t	he cause of d	
al Records,	n: The law requires that icete has been signed b r, page 2 should be deta	Completed		-	Ş	y	er (	20				death?	opsy findings a mpletion of ca 2 No	available ause of
Vital	Physician: ' this certifice ral director, p	To Be	25. Was case referred t edical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	patient 2 ☐ El	P/Outpatien	t 3 DOA	Othor		me 5 Mesic		Other (Specif	5/1	
n of	ding Phys h. After this funeral di		27. Manner Death 1 Taturat 5 Pending	28a. Date of		8b. Time of Injury		Injury at Work?		28d. Describe h			,,	
Division		Certification;	2 Accident investig 3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Place of	of Injury - At hom g, etc. (Specify)	e, farm, str		1 Yes 2		28f. Location (S City or Tov		lumber or Rura	al Route Numi	ber,
	To the Hospital or Attenwithin 24 hours after deati To the Funeral Director: completely filled in by the	Medical Co	29a. Certifier 1 Certifying (Check only one)	Physician: To the taxaminer: On the bas	sis of examinatio	edge, death n and/or inv	occurred at the	ne time, date a my opinion, de	and place, eath occurr	and due to the ed at the time,	cause(s) and	d manner as s	tated. the cause(s)	)
	To the within To the	Me	29b. Signature and title of confider	2	)	10	29c. Lio	cense number	186	7	29d. Date s	igned (Month,	Day, Year)	
(3	C		30. Name and address of person v	vho completed cause		3a) (Type	Print)	fet.	pre	ste	100	Elice	g HW	ty
Y	Sta Registr		31. Date filed (Month, Day, Year)	32. Re	gistraria Signatu	re K	Speed	6	XIU (					
			M1 1/	1 LACO.	-615000	-		~*						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 🛭 🕤 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year 4:42 KM **Physician** TORIL LIVINGSTO 006 /Medical 4c. County of Death 4b. City, Town, of Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospica ithie Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day, Year) Care (In yrs, last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 □ M 2 🕽 F -7563 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location worle! r than "natural", or items 23a or 28a-f ehov the Medical Examiner must be notified at Yes 2□No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Black 1 ☐ Yes 2 📶 No Specify: þ 3 □Widowed 4 □Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 le marked other than "na eny injury or other traumatic event, the Made. College (1-4or 5+) Elementary/Secondary (0-12) was actory NA 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) nderson Gno 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name Relationship (Type, Print) Simba Son Shell Banks Rd. Livingston Baeto, ma, 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □Cremation 3 □Removal from State Comoton Other (Specify) neral Selvice License 22. Name and Address of Facility 21. Signature of Fred HIL 21229 Balto, md. Pimarch Approximate Interval Between Onset and Death ter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Immediate Cause (Finat disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 menths?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 No 200 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) hospics 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manger of Death Certification: 1 Natural
2 Accident 5 Pending investigation al or Attendin s after death. Il Director: Aff 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral I completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Datg signed (Month, Day, Year) Zules 30. Name and address of person who completed cause of death (Item 23a) (Type, Price) DWITE. DOLTEN 32. Registar's Signature 31. Date filed (Month, Day, Year) State APR 0 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 7:24PM 06 1006 Pori 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death orl Balta 100 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs Birthplace (State or Foreign Country) Social Security Number 249-46-384 1 M 2 F South Usual Residence of Decedent 10b. County Town or Location 10d. Inside City Limits attimo 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □ Yes 2 💢 🚾 Specify: Specify Cack 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NIA 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19a. Informant's \*ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or renneth 1 Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Shulerville Wesley Am& Ch. Cem 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dachmi mg, 21229 in vallace na ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, le. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis 3 days Due to (or as a consequence of): 21 Dans 1

Examiner

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

Director

28a-f ehov

or Iteme 23a or death with

"natural".

permit. Pages 1 end 2 should be filed within 7. Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "nt any injury or other traumatic event, the Middle 2006.

**Physician** 

/Medical

the Mudical Examiner must be notified at

Director

Funerai

Completed by

Be

the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

	Se	quentially list conditions,	Due to (ur as a nonsec	openia			30	44.7				
attending physicien and for use as the burial-transit		use. Enter Underlying use (Disease or injury t initiated events culting in death) Last	Due to ( ** s a consec	quence of):	11 Hedder		7	days				
been signed by the attending physicis should be detached for use as the but th	1F 1 23t	FEMALE:  D. Was decedent pregnant  in the past 12 months?  1	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	el death 3 Ecto	opic pregnancy er (specify)		23d. Date of delivery Month Day	Year				
		t II. Other significant conditions con		-		23e. Did tobac	o use contribute to the cause of death?  2 No 3 Probably 4 Munknown					
page 2 should be o		Hypothyroidus	24b. Were autopsy 1 prior to comple death? No 1 \( \text{Yes} \) Yes 2									
his certific	25. Was case referred to medical examiner?  1   Yes   25tNo   Hospital:   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Special Property of the Control of the Contr											
rs after death. al Director: After the		Manner of Death  Natural  Accident  Manner of Death  Death  Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	injury occurred						
after de Directo		3 Suicide 6 Could not be determined	28f. Location (Stree City or Town, S	t and Number or Rural Ro tate)	ite Number,							
within 24 hours after death within 24 hours after death within 24 hours at leader. After this certificate hes completely filled in by the funeral director, page 2 Modical Certification. To Be Company		a. Certifier (Check only one)  Certifying Phys 2 Medical Examin	ician: To the best of my kn er: On the basis of examin- and manner stated.	owledge, death occ ation and/or investig	curred at the time, date and pla gation, in my opinion, death of	ace, and due to the caus courred at the time, date	θ(s) and manner as stated and place, and due to the	cause(s)				
vithir To th comp		Signature, and title of centrier	m.0		29c. License number		Date signed (Month, Dey,	,				
	× 5	Name and address of person who con	10 201 Ea	st Unive	vsity Parkway	Beltimore 1	MO 21218					
State	31.	Date filed (Month, Day, Year)	32. Registrar's Sign	ature								

DHMH 17 Rev 1/2001

State Registrar

6

32. Registrar's Signature

APR 1 0 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Lock lear Month Bay Year **Physician** 330 4 05 a 2006 4pri /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Balti more Burton Care Pavillion John If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/23/1924 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🕶 F Days Hours 246-52-8019 31 Yrs Director North Carolina Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c, City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show 27 is marked othar than "natural", or Items 23a or 28a-f shov traumatic avent, Ite Modical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Charlesmont Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7865 Charlesmont Road 21222 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: American 3 Widowed 4 □ Divorced Indian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. I othar than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be n and Mental I Less Norman Locklear Lillie Mae Jacobs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if itam 27 is any injury or other tra Maurice Locklear - Son 7865 Charlesmont Road Raltimore, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 04/10/2006 Baltimore, Maryland David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, MD 21231 athless 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician arrhythmia minutes disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause & Lisase or ir jury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. | the à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, pe dementia 2 No 3 ☐ Probably 4 ☐Unknown 1 Yes director, page 2 should Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No arthritis certificate has rmed? 2 X No 1 Yes or Attanding Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification; To ursing Home 5 Residence 6 Other (Specify) this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending after death. death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a a Funaral I Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To tha 29b. Signature and little of certifier 0 D0056806 ddress of person who completed cause of death (Item 23a) (Type, Print) Bayview Circle Baltimore, MD 21224 5505 31. Date filed (Month, Day, 32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

2006

State of Maryland / Department of Health and Mental Hygiene [] [] [ Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 4:15 рм Margaret Naomi Leppo April 2006 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M XXF 84 Yrs. Director 216-12-6109 Sep. 4, 1921 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Madical Examiner must be notified at 1 Yes XXNo Funeral Director Maryland Baltimore Lutherville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America items 23a 1501 Pickett Road 21093 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2**XX**\o If Yes, Give Year or Dates: 1 Never Married 200 Married ŏ 1 ☐ Yes **¾**(XNo þ Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: if item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12th Broadcasting Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) George Henry Dixon Catherine May Hayes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Depertment of Health ar
Important: if item 27 is
any injury or other trau Lutherville, Maryland 21093 E. Ray Leppo (Husband) 1501 Pickett Road; 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 anation and moval from State 4 Donation (Other (specify) April 7, 2006 Park Cemetery 2006 Baltimore, Maryland 22. Name and Address of FacilityLoudon Park Funeral Home 3620 Wilkens Avenue Baltimore, Maryland 21229 Loudon Park Cemetery 21. Signature of Fu def. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** metastatic breast years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 **X**No or Attending Physicien: : After this certifical funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nther (Specify) ၉ 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation ours after death. nere! Director: Afi filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funerel Direct completely filled in by 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 I Medical Examilater: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00051926 april 3,2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St Balhamore 6565 N. MO M. Gordon 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

P.O. Box 68760,

Division of Vital Records,

2006

Funera

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 1 C

5	- 1	0	1	1
	- 2	1.1	1.	-1-1
	- 1	[ ]	4-5	

	Directo
Causon, Nelson Baltimore Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Marhall Hygiene. Important: if item 27 is marked other then "natural", or Items 23a or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at
•	Physiciar /Medica Examine
	Examine
Division of Vital Becords, P.O. Box 68760	To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

•	1 - For State Registrar	0.0.0	C	ertificate of	Death	Reg.	ZUUU	11040			
	Decedent's Name (First, Middle, La	ast)				2. Date of Death	Day Year	3. Time of Death			
ian ical		Nelson T.	Laws	on		APril 0		2: 5/PM			
ner	4e. Fecility Name (If not institution, gir	ve street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	ath			
		race Hospita		Lose	dale		Waltin	nore			
	9	Sex 7. <b>A</b> ge ( <i>In yr</i> : 1⊠M 2□F 53	s. last birthdi Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day, Ye	ear) C	rthplace (State or Foreign ountry)			
	231-74-3931 Usuel Residence of Decedent	33				Jan. 22,	1953   Vi:	rginia			
	10a. State 10b. County	10c. (	City, Town or	Location				10d. Inside City Limits			
2	Maryland Bai	ltimore		Po	sedale			1 ☐ Yes 2 💢 No			
Director	10e. Street and Number	ICIMOLE		10f. Zip Code	sedare	10g.	Citizen of What C	ountry?			
- 1	1334 Evering Av	ve.		21	237		United St	tates			
Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 1	Was Decedent of H     If Yes, specify Cuba	dispanic Origin? (Spe	cify Yes or No-	14. Race - Am				
	1 ☐ Never Married 2 ☐ Married	1 X Yes 2 □ No		1 ☐ Yes 2 No		nicari, etc.)	Black, Whi				
<u>ה</u>	3 ☐ Widowed 4 ∑ pivorced	Year or Dates: Viet	nam	1 10s 221No	зреспу.		Specify:	White			
	15. Decedent's E (Specify only highest gr	ducation ade completed)	(G	cedent's Usual Occupive kind of work done	during most of working	16t	. Kind of Business	s/Industry			
Ì	Elementary/Secondary (0-12)	College (1-4or 5+)	- life	a. DO NOT use retired	d)			Air			
5000	6 Years			Mecha				Conditionin			
מ	17. Father's Name (First, Middle, Last	y .			18. Mother's Name						
2	Louie Lawson					lphia Har					
	19a. Informant's Name/Relationship	. ,, . ,		ailing Address (Street							
	Virginia Festerma			334 Everin		osedale,		21237			
	20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐	Removal from State	cemetery, c	sposition (Name of crematory or other place	ce)		c. Location - City or	r Iown, State			
1	*4 □ Donation 5 □ Other (Speci		Iillto	Service		/2006 T	owson, Ma	aryland			
	21. Surfacture of Funeral Service Lice	neee /	$O \mid$	22. Name and Addre Duda-Ruck	ss of Facility Funeral H	Home of D	undalk.	Inc.			
	1 XX	- Cine		7922 Wise	Ave. Dun	dalk, Maı	cyland 2	1222			
1	23a. Part1. Enter the disease, or com- shock, or heart failure. List only	one cause on each line.	ath. Do not	enter the mode of dyir	ng, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death			
	Immediate Cause (Final disease or condition HYPO/EMSID N										
	Due to (or as a consequence of): RESPIRATORY FAIWRE										
	4 days										
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conse	. ,	2 - 00				1 0 0 1 1			
0	Cause (Disease or injury that initiated events resulting in death) Last	c		COPD				4 years			
	resulting in coatiny Last	Due to (or as a conse	equence of):					O.			
E Ca		_ d									
Medical	IF FEMALE:										
Physician	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preging 1 Live birth 2 Fe	tal death	3 ⊑Ectopic pregnancy	,		23d. Date of de Month	livery Day Year			
3	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death	5 Other (specify)				22,			
1		agentalbuting to double but	noultin - i- at	. undadaine	an in Dard !	220 Did tot	no una accessione s	o the poure of death?			
2	Part II. Dther significant conditions	Coll Line	esuiting in the	underlying cause giv	en in Part I.			o the cause of death?			
	14011 311101	and wo	1 0	may		1, Yes	2 □ No 3 □ P	robably 4 Unknown			
nanaldino						24a. Was an autopsy		utopsy findings available completion of cause of			
5						performed	death?				
	25. Was case referred to medical examiner?				26. Place of Death	(Check only one)					
	1 Yes 2 No	Hospital: 1 Inpatient 2[	☐ ER/Outpat	ient 3 DOA Oth	er: 4 Nursing Hon	ne 5 🗆 Residence	e 6 □Other (Spe	ecify)			
	27. Many or of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injur		y at 2	8d. Describe how i	njury occurred				
	2 ☐ Accident investigatio	n	1		Yes 2 □ No						
	3 Suicide 6 Could not be determined		home, farm,	street, factory, office	2	8f. Location (Stree City or Town, S		ural Route Number,			
						(1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-					
	29a. Certifier 1 Certifying Pl	hysician: To the best of my kr	nowledge, de	eath occurred at the tin	ne, date and place, a	nd due to the caus	e(s) and manner a	s stated.			
	one)	miner: On the basis of examinand manner stated.	iattion athovor	investigation, in my o	pinton, death occurre	u at the time, date	and place, and du	e to the cause(s)			
	29b. Signature and title of certifier	1/		29c. Licens		29d.	Date signed (Moni	th, Day, Year)			
	Suman	llau MD		105	7703	4	11/06				
1	30. Name and address of person who			pe, Print)							
	9103 FRANKLIN	1 SQUARE I	DRIVE	E, ISAU	TIMORE	MD	2123/				
,	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	. M .							
ar	APR 1 0 20	OS Menses La									

06-02374 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Mitchell, Curtis 1- For State Certificate of Death Registrar Physician/ Decedent's Name (First, Middle, Last) 2. Date of Death Month Day April 6, 2006 17:59 Medical Examiner Curtis Earl Mitchell III 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital Baltimore City 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) Months Days Hours Director 212-11-4591 1 X M 2 10-10-1985 20 Maryland | Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 X Yes 2 No 28a-f show Pages I and 2 should be filed within 72 hours after death with the Maryland nen of Health and Mental Hygiera.

The Health and Mental Hygiera and an analysis of riems 23a or 28a-f sho and I. If item 27's marked other than "natural", or items 23a or 28a-f sho and I. If item 27's marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3018 Clifton Park Terrace 21213 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12 Was Decedent Ever in U.S. 11 Marital Status Race - American Indian, Black. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married 2 X No Yes Divorced If Yes, Give Year Black. 3 Widowed 1 Yes 2 X No specify: Specify. ģ or Dates 15 Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during Elementary/Secondary (0-12) College (1-4 or 5+) most of working life. DO NOT use retired) 3altimore, MD 21215-0036 Delivery 10 Laborer 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Curtis Mitchell Jr. Shantell Gambril 19a, Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3018 Clifton Park Terrace Baltimore, MD 21213 Shantell Gambrill/ Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c Location - City or Town State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Mt. Zion Cemetery 04-13-06 Lansdowne, MD 4 Donation 5 Other Specify: -21. Signature of Funeral Service Licenses 22. Name and Address of Facility Sunerla yones Wylie Funeral Home 638 N. Gilmor Street Balto, MD 21217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical a Multiple Gunshot Wounds Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit The law requires that the death certificate be executed d sician/Medical g physician a UNPENDED AMENDED Box 68760 IF FEMALE: 23b Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d Date of delivery attending por use as the Live birth Fetal death Ectopic pregnancy Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 V No 3 Probably 4 Unknown Completed ficate has been si page 2 should b 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 ✓ Yes 2 No 1 🗸 26 Place of Death (Check only one) 25. Was case referred to medical examiner? Other:
Nursing Home 5 Residence 6 Other: Hospital: 1 ☐ Inpatient 2 ✔ ER/Outpatient 3 DOA 1 V Yes 28a. Date of Injury FOUND: 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject was shot FOUND: Natural 1 Yes 2 V No 5 Pending Director: Accident Apr 6, 2006 17:26 Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 \_\_\_ Suicide Could not be or Town, State)
2019 North Longwood Street, Baltimore City, Md (Specify) Local Street determined within 24 hours a 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c, License numbe, 29d. Date signed (Month, Day, Year) O.C.M.E. April 7, 2006 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD 31. Date filed (Month, Day, Year) Personal States Registrar

DHMH 17 Rev 1/2001 OCME 10/2003 ORIGINAL

State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 3, 2006 **Physician** 6:30 Manown рм Patricia /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A 2808 Carroll Street Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. June 12, 1940 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Maryland 1 M 2 F 219-26-7641 Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-4 show any injury or other traumatic event, the Machical Examiner coust be notified at once. 1 Yes 2 No Baltimore Directo Maryland N/A 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21230 USA 2808 Carroll Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Medical Office 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Betty Augustauskas Hunker Ε. William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2808 Carroll Street, Baltimore, MD 21230 Dale Osborne (Per Rep) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Baltimore Crematory @ 4/11/06 <sup>1</sup> 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part : Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PANCEATIC CARCINOMA ADVANCED **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and ched for use as the burial transit Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 5 ☐ Other (specify) signed by the aid be detached for 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DERIENSION 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No been DEPENDENT DIABETES MONINSULIN 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? CARCINOMA ULVAL 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 \_\_Inpatient 2 \_\_ER/Outpatient 3 \_\_DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို this 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred completely filled in by the funeral 28a. Date of Injury (Month, Day Year) after death. 28b. Time of Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after to the Funeral Direct 4 Momicide 1 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 4-10-06 and the 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3721 POTEE St. BALTIMORE, MD 21225 KIS DHARMASONA, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink

oulton, William		St 1- For State Registrar	tate of Marylar	nd / Dep	artment o	f Health ar	nd Mental		Reg No.	2006	5 1105
Physicia ledical Examir		Decedent's Name (First, Middl						2. Date of D Month	Day	Year	3 Time of Death 10:25 AM
ledicai Examii	ier	William G.	Mou1 tor			4h City Town o	r Logotion of Dog	April 4,		ounty of Death	
) _		4a. Facility Name (if not institutio 3101 Hollyberry Ct.	in, give street and num	ber)		4b. City, Town, o Abingdon	Location of Dea	att 1		ford	
Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs.	last birthday)	If Under 1 Ye		lin i		Co	thplace (State or Forei un <u>tr</u> y)
Director		215-56-5233	1 X M 2 F	55	Yrs		ys Hours IV	"" March	18, 195	1 Mar	rylánd
ž:		Usual Residence of Decedent  10a. State 10b. County		100 City	, Town or Locat	ion					10d. Inside City Limit
ow any			rford	100. 01	Abingdon	1011					1 Yes 2 X N
Aaryland 28a-f show I at once.	cto	10e. Street and Number			7 D Trigaon	10f. Zip Code			10a Citizen	of What Cour	
the Ma Sa or 28	Director	3101 Hollyberry Cou	ırt			21009			USA	or rivial ood	
n with ms 23 be no	eral	11. Marital Status	12. Was Deced			as Decedent of H			No- 14.	Race - Ameri White, etc.	ican Indian, Black,
death or ite	Funeral	1 Never Married 2 X M	1 X Yes	2 No		es, specify Cuba		to Rican, etc.)		White	
s after ral",	by		vorced If Yes, Give Year or Dates:		1		o specify:			ecify:	
hour "natu	ted	<ol> <li>Decedent's Education (Spe Elementary/Secondary (0-12)</li> </ol>			during	nt's Usual Occupa			16b. Kind	l of Business/I	Industry
MD 21215-0036 1.2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene 1.27 is marked other than "natural", or items 23a or 28a-f shoundire event, the Medical Examiner must be notified at once	Completed	12	College (1-2	+0151)		working life. DO Or Pool	NOT use retired)		U.S.	Army	
5-0 iled v Hygi I othe		17. Father's Name (First, Middle,	. ,				18.Mother's Nar			name)	
2121 uld be fi Mental B marked	Be .	William G. Moultor  19a Informant's Name/Relations			10h Mailin	g Address (Stre	Mary Eil			or Town State	Zin Code)
AD 21215-00; 2 should be filed with h and Mental Hygiene 27 is marked other ti martic event, the Med	ဥ	Amelia Moulton /Wi				Hollyberr					
and and fealt fealt trau		20a. Method of Disposition		20b.	Place of Dispos	sition (Name of ce		Date		ation - City or	
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		1 Burial 2 X Cremation		1117	crematory or ot		4	/7/06	Tour	an Main	loud
Itimer Partmer ortan		4 Donation 5 Other St. 21. Signature of Funeral Service	pecify: Licensee <b>Christ</b>	ina L.	Hilton 22.1	Name and Addres	ss of Facility	, , , , ,	TOWS	son Mary	iand
Balti permit. Departm Importa		Objection N	× 41.77		Le	eonard J. 305 Harfor	Ruck, Inc	iltimra	Maryland	1 21214	
Physician		23a. Part I. Enter the disease, or		used the deat							Approximate Intervi
/Medical		failure. List only one cause Immediate Cause (Final disease		nd narc	otic (met)	hadone) ir	tovicatio	n			Between Onset an Death
Xaiiiiiei		or condition resulting in death)	Due to (or as a c	consequence	of):	icatoric) ii	icoxicatio	11			
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a c	oneed lence	of):						
	nine	cause. Enter Underlying Cause (Disease or injury that initiated		orisequerice	01).						
d sit	Examiner	events resulting in death) Last	Due to (or as a c	consequence	of):						
be executed sician and urial - transit		V	d.	السخ مصلا1 00	- 27 20	C	DEE E /10 /0	C (TTT)			
	edical	X UNPENDED				f,perME,g8	55,5/18/0	o TT			
Box 6876C: death certificate he attending physic for use as the b	Physician/M	IF FEMALE: 23b. Was decedent pregnant in th	he 23c. If yes, ou			etal death 3	Ectopic pred	anancy		ate of delivery	y Day Year
x 61 th cert tendir	icia	past 12 months?	4 Pregna	nt at time of o	tooth	ther (Specify)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			,
Bo le dear the ar	hys		9 Unknow								
P.O. Ess that the digned by the	by P	Part II. Other significant condit	ilons contributing to d	death but not	resulting in the	underlying cause	given in Part I.				the cause of death?
S, P.C puires that an signed ald be deta	ed										,
cords law requi	blet								topsy	prior to c	itopsy findings availab completion of cause of
Rec The la	Completed							1 <b>✓</b> Ye	rformed? s 2 No	death? 1 ✔ Ye	es 2 No
ital Recician: The scertificate rector, page	Be	25. Was case referred to medica examiner?				26.Plac	ce of Death (Che	- ,			
F Vid	2	1 Yes 2 No		patient 2	ER/Outpatien		Other Nur				r: Scene
n of ding Pl After funera		27. Manner of Death  1 Natural 5 Pend		f Injury Day,Year)	28b. Time of		ury at Work? Yes 2 X No		be how injury o	occurred	
Sio Atten death ector:	cati		estigation Fnd 4/4		Fnd 10:1	3 am		unk	(0)		
Division of Vital Records, tal or Attending Physician: The law requirers after death all Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	dete	ald not be cermined (Specify)			et, factory, office	bullding, etc.	or Town	n State) 31	Ol Holly	iral Route Number, Cit yberry Court
lospit Hour Juners		29a. Certifier 1 Continue P	(0,000.7)	found a		rrad at the time	data and place of	Abingd	-	CORDO AS ALAM	tod
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical	(Check only Certifying P	Physician: To the best aminer:On the basis of	examination							
To wit	Mec	29b. Signature and title of certifie	and manner sta er	ated.		29c, Licen	se number		29d. Date	e signed (Mo	nth, Day, Year)
		11/1/	1 7.0			0.0	.M.E.		ul o	(06	
		30. Name and address of person	who completed cause	of death (Ite	m 23a)				(13	1 - 70	
		Theodore King MD.	Assistant Medic	,		enn Street, B	altimore, MD	21201			

Registrar

Theodore King MD. Assistant wood.

State 31. Date filed (Month, Day, Year)

APR 1 0 2006

ORIGINAL

DHMH 17 Rev 1/2001 OCME 10/2003

			1 - For State Registrar	State of Ma	arylan				ealth a Death	and M		giene Reg. Nö.	06	11052
ı	Physici		1. Decedent's Name (First, Middle, Last)  Mary Catheri	ne Mahon	ey						2. Date of De		)6 Year	3. Time of Death 12:40а м
	/Medic Examir		4a. Facility Name (If not institution, give s Blakehurst	treet and number)			4b. City,		Location of	of Death			ity of Death	
	Funeral Director		210 14 4022	7. Age	84	ast birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da OCt. U	th Year 1921	9. Birth Oh'i	place (State or Foreign ntry)
	e Maryland e-fahow lifted at	ctor	Usual Residence of Decedent  10a. State 10b. County  Md. Baltimore	e	1507	nkton	cation							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	th with th	al Director	10e. Street and Number 16829 Wesley Cha	pel Rd.			10f. Zip 21	Code 111				10g. Citizen of What Country?		
9036	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other then "natural", or Items 23e or 28e-f ahow or other traumatic event, the Madical Exacultrational by multiple at	Completed by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ※ Widowed 4 □ Divorced	11	Vas Decec Yes, spec	offy Cuba	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	ecify Yes or No Rican, etc.)	or No- Specify: White, etc.				
Maryland 21215-0036	d within 72 ho giene. sr then "natu	completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		+)	(Give I life. L	B kind of work done during most of working DO NOT use retired)					16b. Kind of Interi		
yland	ould be file Mental Hy arked oth atic event	To Be (	17. Father's Name (First, Middle, Last) John Flannery							r's Name Cili		, Maiden Suma aney	ame)	
, Mar	and 2 sho ealth and m 27 is mu		19a. Informant's Name/Relationship ( <i>Typ</i> Mrs. Kate Daley/ De		• • • • • •	2002	West	ches		\ve.	Baltim	er, City or Town		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tras		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)	ace of Disposemetery, crem	alley	ther place Mem	1.	-11-		Timon	on - City or Town, State			
Ball	Departiment Departiment Departiment Departiment Department Departm		21. Signature of Funeral Sentice License						Home: I	nc 1204				
X	Physician and // // // // // // // // // // // // //	Examiner	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Erne, Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequ	Mence of):		e of dying		cardiac o	r respiratory a	rrest,		Approximate Interval Between Onset and Death
.O. Box 68760,	ath certii attending for use a	Physician/Medical I	IF FEMALE: 23b. Was decedent pregnant in the past 12 rofnths? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of 1 Live birth 1 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3 🗌	Ectopic pro Other (spo					23d. D M	ery Day Year	
Records, P.	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions con		A /	lting in the un	4	ause give				obacco use cor res 2 PNo		he cause of death?
		Completed	Temenul				_		rmed? 2 D No	Were auto prior to co death? 1  Yes	psy findings available impletion of cause of			
ion of Vital	ing Phys	ation: To Be	25. Was case referred to medical examiner?  1   Yes   2   No	3 DO	Bc. Injury Work	r: 4 Nur	sing Hom 2		ene) dence 6 ⊡Ot now injury occu		(y)			
Division	itel or Attencus after death	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc	. (Specify	)					City or Tox	vn, State)		al Route Number,
	To the Hospitel or Att within 24 hours after d To the Funeral Direct completely filled in by	Medicai	29a. Certifier   1   Certifying Phys   2   Medical Examin	er: On the basis of and manner stat	examinati	viedge, death on and/or inv	estigation,	in my op	inion, deat	l place, a h occurre	d at the time,	date and place	, and due to	the cause(s)
		<	29b. Signature and title of certifier	aly m	(1)		29c.	)30	433	3	j	29d. Date sign	od (Month,	Day, Year)
	10		30. Name and address of person who cor	CABMIC	ath (Item	23a) (Type, F	rint)	HAR	UES	51	B	HTIMO	RE	006 M021204
• *	Sta Registr	-	31. Date filed (Month, Day, Year) APR 1 0 20	32. Régistra	r's Signati	3. M		7						

			1 - For Stata Registrer	State o	f Maryland		artment rtificate					giene Reg. No.	006	Printerplane	53
			1. Decedent's Name (First, Midd		-				2. Date of Dea	ath		3. Time	of Death		
	Physic		GEORGIA KA	THERINE !	JIMICK						Month MARCH	Day 31	Year Zoo6		-
	/Medi Examir		4a. Facility Name (If not institution				4b. City, T	Town, or	Location of	of Death	100th Cut		ounty of Death	13.30	
1	LAGIIII		1920 Ouentin F	Road			,		ndalk				Baltim	0200	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under		If Under		8. Date of Birt	h			or Foreian
	Director		217-10-5561	1 □ M 2020 F	89	Yrs.	Months	Days	Hours	Min.	NOV . 4			place (State ntry)	rginia
	9		Usual Residence of Decedent	1,,							1100.	.,	0 1 1/0	DC VI.	-911110
	how		10a. State 10b. County	<i>'</i> ·	10c. City,	Town or Lo	cation							10d. Inside (	City Limits
	e Ma	턍	Maryland	Baltimore					Dur	ndalk				1 □ Ye	s 2000 No
	or 28	Director	10e. Street and Number				10f. Zip (	Code				10g. Citize	n of What Cou	ntry?	
	th wi		1920 Quentin	Road					212	222		Un	ited St	ates	
	dea	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.S		Was Decede	ent of His	spanic Ori	gin? (Spe	ecify Yes or No-	14	. Race - Ameri		
9	72 hours after death with the Maryland "natural", or Itama 23a or 28e-f show offest Exertities in Nat be rutified at	正	1 Never Married 2 Mar		2000No		fYes, speci 1□ Yes 2			i, Fuerto	nican, etc.)	_	Black, White,	etc.	
21215-0036	ours ral',	d by	3 XWidowed 4 ☐ Divorced	Year or D			1145 4	₹¥140	Specify:			S	ре <i>cify:</i> W	hite	
5	d within 72 ho plene. r than "natur the Medical	Completed	15. Deceder	nt's Education est grade completed)		16a. Deced	dent's Usual kind of work	Occupa	tion	t of work	na .	16b. Kind	of Business/In	dustry	
21		du	Elementary/Secondary (0-12)	College (1	I-4or 5+)	life. I	DO NOT use	e retired)	ur ing mooi	. 01 1101111	.,9				
		S	12 Years			Home	emaker						Home		
밀	be file ital Hyg id otha avent,	Be	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name	(First, Middle,	Maiden Si	umame)		
<u>S</u>	should be find Mental Finarkad of	ဥ	Wilmer Null						M	lary	Edith K	Celly			
Maryland	0 0 00 00		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	g Address (	Street a	nd Numbe	r or Rura	l Route Numbe	r, City or 1	Town, State, Zip	Code)	
	1 and 2 Health		Mrs. Deanna	Effland (Da	aughter)	1920	O Quer	ntin	Road	l Du	ındalk,	Mary!	land 2	1222	
Baltimore,	00-		20a. Method of Disposition	s	COL	ice of Dispo	sition (Name	e of ner place	,)	C	ate	20c. Loca	tion - City or To	own, State	
Ĕ	permit. Pages Department of I Important: If its any injury or or		1   Burial 2 □ Cremation  1 □ Donation 5 □ Other (S		State	st La	•		1	/4/2	2006	Svk	esville	. MD	
a	mit. partn sorts / inju		21. Signature Funeral Service	Licensee	, 020	22	. Name and	Address	of Facilit	y				,	
m	permi Depa Impo any ir		Must G			Di	ıda-Ru	ıck l	Tuner	al E	ome of adalk, N	Dunda	alk, In	c. 222	
			23a art1. Enter the disease, o shock, or heart failure. List	emplications that co	aused the death.								ana zi	Approxima	ite
	Dhamaina		immediate Cause (Final											Interval Be Onset and	tween Death
	Physician / /Medical	1	disease or condition resulting in death)	a. 3695	or as a conseque								_	300	YS
	Examiner	11			ULCER	•	=.							1	1
		e	Sequentially list conditions, if any, leading to immediate		or as a conseque									1 140	NTTH.
VS	uted I Insit	Examin	cause. Enter Underlying Cause (Clsease or injury	DEU	ENTIA									3 YEA	
1	al-tra	Ха	that initiated events resulting in death) Last	0,	or as a conseque	ence of):								2 46	462
68760,	icate be executed physician and s the burial-transit	alE											1		
987		edical		d											
_	Attanding Physician: The law requires that the death certif rotath.  **Crobath**  *	/We	IF FEMALE:	23c. If ves. out	come of pregnanc	cv						-	10. (10		
Вох	at the death certi by the attending stached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bi	irth 2 ☐ Fetel d ant at time of dea	leath 3	Ectopic pred					230	<li>Date of delive Month</li>	-	Year
P. O.	the d	ysle	1 □ Yes 2 🛣 No 9 □ Unknown	9□ Unkno		ui 5 🗀	Other (spec	cuy)							
	res that i	'Ph	Part II. Other significant condition	ons contributing to de	ath but not result	ina in the un	iderlying cau	ISA CIVAR	in Part I	<del></del>	23e. Did to	bacco use	contribute to th	e cause of	death?
Records,	sign sign d be	d by		OKE COLO						10	1 □ Y			ably 4 🗌	
Ö	w require been si should b	ete	71,70		00.00		100	-(-	U)()	4	-	-7			
š	has has	Completed									24a. Was a autops	sy		psy findings npletion of (	available cause of
=	: Th cate	S									perform 1 ☐ Yes	ned? 2.K. No	death? 1 □ Yes	2 No	
Division of Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medica examiner?							of Death	Check only on	(0)			eterar 2
5	Physic this c	은	1 ☐ Yes 2 📈 No			R/Outpatient	3□ DOA	Other	4 Nur	sing Hon	ne 5 🗆 Reside	ence 6 🛭	Other (Specif)		DME
_	ding F h. After funera	Certification:	27. Manner of Death 1 ★Natural 5 ☐ Pendin	28a. Date o (Monti	of Injury 2 h, Day Year) 2	8b. Time of Injury	280	C. Injury a Work?	at	2	8d. Describe ho	ow injury o	ccurred		
<u>s</u>	tand leath tor: / the f	cat	2 Accident Investig				М	1 🗆 Ye	es 2□N	10					
$\geq$	or At after of Diraci	Ti.	4 Homicide determ	ined 288. Place	of Injury - At hom ng, etc. <i>(Specify)</i>	e, farm, stre	et, factory,	office		2	8f. Location (St City or Town	reet and N n, State)	lumber or Rura	l Route Nun	iber,
	ospitel hours a uneral D														
	Hospitel or Attana 24 hours after deatl Funeral Diractor: 1ely filled in by the	edical	Consect Only 2   Medical	g Physicien: To the Exeminer: On the ba	isis of examinatio	edge, death	occurred at	the time	, date and	l place, a	nd due to the ca	ause(s) an	d manner as st	ated.	(2)
	To the Hospitel or Attanding Physician: The willin 24 hours alter death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Med		and mann	er stated.										7
	To Toon	2	29b. Signature and title of certifie	. /	1		29c. l	License	number		2	9d. Date s	igned (Month, I	Day, Year)	
			Jemen	Hunas	2		D	62	037	2	A	PRIL	03	2000	, .o
	17		30. Name and address of person	who completed cause	of death (Item 2	3a) (Type, F	Print)								
	1			YASHI, 5	of death (Item 2	OPKIN	15 B	KYVI	EN	CIR	CLE B	ALTTI	MORE	MD Z	1224
	Sta	_	31. Date filed (Month, Day, Year)	32/Re	egistrar's Signatur	e See	. 64								
	Registra	ar	APR 1 0	2006	was St	630									

			For Stete Registrar	State o	f Marylar		artment o				ene	6	1054
	q . *		Decedent's Name (First, Midd	lle, Last)						ate of Death		Year	3. Time of Death
	Physic /Medi		Margaret Gor	don Ownley	<i>T</i>					RIL		006	3:30 A M
	Exami		4a. Facility Name (If not institution				4b. City, Tow	m, or Location of	of Death		4c. Count	y of Death	
			GREATER BALT				TOWS		24 Hrs.   a.m.			IMORE	
	Funeral Director		5. Social Security Number 229–22–6686	6. Sex 1 ☐ M 2 ∏ F	7. Age (In yrs. 88	. iasi birinday) Yrs.	Months Da		Min. (A	ate of Birth Month, Day, 1			place (State or Foreign
			Usual Residence of Decedent						ret	20,	1910		Carolina
	anylan show	_	10a. State 10b. Count		10c. Ci	ty, Town or Lo						1	0d. Inside City Limits
	r the Marylan r 28e-f show	ecto	MD Balt  10e. Street and Number	imore		Tows							1 ☐ Yes 2 ₹ No
03	death with the Maryland ms 23e or 28e-f show	Funeral Director	800 Southerly	Road #808			10f. Zip Cod		21286	10	g. Citizen of	What Cour	ntry?
U	death	nera	11. Marital Status	12. Was Deci	edent Ever in U	J.S. 13.	Was Decedent	of Hispanic Ori	gin? (Specify	res or No-		ce - Americ	
\_ <u>\</u>	within 72 hours after dea ene. then "natural", or Items to Wedical Examiner or		1 X Never Married 2 ☐ Ma	rried 1 ☐ Yes			ii Yes, speciny 0 1 □ Yes 2100 l		i, Puerto Hican	i, etc.)		ack, White, %: Whi	
77	hours lural',	d by	3 Widowed 4 Divorce	Year or D	ates:								
Margar E	in 72	Completed	(Specify only high	nt's Education est grade completed)		(Give	dent's Usual Oc kind of work do DO NOT use re	ne durina mos	t of working	11	6b. Kind of E	susiness/ind	ou stry
4	d with giene	mo	Elementary/Secondary (0-12)	College (	1-40r 5+)	en	gineer				Bell	Atla:	ntic
Sa	be filed tall Hygie d other event, it	Be	17. Father's Name (First, Middle	•					er's Name (Firs				
< <u>a</u>	2 should be filed within 72 hours after dea and Mantal Hygiene. Is marked other then "natural", or Items toungit event, the Madical Examiner or	은	Buchanan Own						rgaret				
EY, MargarE	d 2 sh th and th sn treum		19a. Informant's Name/Relation Linda P. Yend				ng Address (Str Verdig						Code)
	s 1 and 1 Health (fem 27		20a. Method of Disposition		20b. F	Place of Dispo	sition (Name of	1	Date	-	Dc. Location	- City or To	wn, State
> 2	Pages nent of I int: If its		1 ☐ Burial 2 ☐ Cremation 1 4 ☑ Donation 5 ☐ Other (-		State	сетпетегу, сте	matory`or other	piace) i					
OWILL	permit. Pages 1 and 2 should be Department of Haalth and Menta Important: If item 27 Is marked any injury or other treumetic as <u>once.</u>		21. Signature of Funeral Service Ronal Co	S. Wade, I	Serve :		2. Name and Ad tate Ana	dress of Facility atomy B		55 W. 1	Balt <b>i</b> n	ore S	treet
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that	aused the deat		altimore er the mode of		21201 cardiac or resp	oiratory arres	et,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	t only one cause on e		1 200. 1	E He	ank	4 00	·c.			Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conseq		0 /10		200				ready
	LAdililiei	_	Sequentially list conditions,	b	المعادي معادي								
_	ited nsit	Examiner	r any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<b>Custo</b>	UI as a conseq	quanta (ii).							
	cate be executed only sician and the burial-transit	Exal	that initiated events resulting in death) Last	c. Due to	or as a conseq	quence of):							
8760	ate be ohysicia	dlcal		d									
9	as as	a a	IF FEMALE:								1		-
S	eath certific attending p	ian/	23b. Was decedent pregnant in the past 12 months?		inth 2 ☐ Feta	al death 3	Ectopic pregna				1	ate of delive	nry Day Year
C	at the de by the a	Physician/M	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∐Pregn 9☐Unkno	ant at time of down	leath 5L	Other (specify	)					
۵	The law requires that the death certification is the has been signed by the attending page 2 should be detached for use as	by Ph	Part II. Other significant condit	ons contributing to de	eath but not res	sulting in the u	nderlying cause	given in Part I.	2	3e. Did toba	cco use con	tribute to th	e cause of death?
rds	v requires been sign should be	d ba	Congester	· hear	Jack	u, Co	lonace	z arte	Ly !	1 🗆 Yes	2 XN0	3 🗌 Prob	abiy 4 Unknown
O O	law re as bee 2 sho	Completed	direase (	honic x	enal	dise	ese,	シェク	Sm 2	4a. Was an autopsy	24b.	Were autor	psy findings available appletion of cause of
ğ	The ta	E O	gout . C	000			,		_ 1	performe	ed?	death?	
/ita	iclen: Th	Be (	25. Was case referred to medical examiner?						of Death (Che	ck only one)			
J-	Physi this o	2	1 ☐ Yes 2 No 27. Manner of Death			ER/Outpatier	I 3 DOA		rsing Home	5 🗌 Residen Describe how			)
2	ding th. After funer	tion	1 Natural 5 ☐ Pendi	ng (Moni	of Injury th, Day Year)	Injury	\	njuryat Work? I∐Yes 2∐I		Pescribe flow	inquity occur	Hed	
Division of Vital Records P O Rox	Attending Physicien: r death. ector: After this certificaby the funeral director,	ifica	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place	of Injury - At he	ome, farm, str	eet, factory, offi		28f. Lo	ocation (Stre	et and Num	ber or Rura	I Route Number,
į	urs afte	Certification;	4   Nothicide	Dulidi	ng, etc. (Specif					ity or Town,		<u>.</u>	
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 Certifyi 2 Medicel one)	ng Physician: To the Examiner: On the ba and mani	best of my kno asis of examina ner stated.	owledge, death ation and/or in	n occurred at the vestigation, in m	e time, date an ny opinion, deat	d place, and du th occurred at t	ue to the cau the time, date	se(s) and m e and place,	anner as st and due to	ated. the cause(s)
	To the within 2 To the comple	Σ	29b. Signature and title of certific	,	10 .	***		ense number	0	290	I. Date signe	ed (Month, I	Day, Year)
			Mord		Cor.			1618			7/9	1/20	006
			30. Name and address of person	who completed caus	e of death (Iten	n 23a) (Type,	Print)	5 N.C	had	St. H	615-7	ous	2120x
	Sta	te	31. Date filed (Month, Day, Year	) 32/R	egistrar's Signa	ture And	rate)		- 7/	- 01			21204
	Danie		ADD 1 O	2006 /	5.100 h	30 M							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydienes and

			For State Registrar		State of	warytan		artment of i <i>tificate of</i>	rieaith and i <i>Death</i>	Mental H	ygiene Reg. No.	006	11055
	Physici /Medic		1. Decedent's Nam		sst) KIMBERL	Y MIC	HELLE	PETTIS	S	2. Date of D Month		Year	3. Time of Death  5-35 AM
	Examir		4a. Facility Name (	f not institution, giv	ve street and numb	er)		4b. City, Town,	or Location of Deat	h	4c.	County of Death	
					TAL CEN			WESTM				CARROL	
ر ج	Funeral Director		5. Social Security N 219-06- Usual Residence of	7363	Sex 7. 1□M 2⊠F		23 Yrs.	If Under 1 Year Months Days		8. Date of B (Month, D	irth Da <i>y</i> , Ye <i>ar)</i> /198	9. Birth Cor	hplace (State or Foreign untry) YLAND
17	yland now		10a. State	10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
Sin	death with the Maryland ims 23a or 28e-f show	ctor	MD	CARROI	LL	WES	STMINS	STER					1⊠Yes 2□No
Lu.	or 28	Oire	10e. Street and Nur					10f. Zip Code			10g. Citiz	en of What Co	untry?
Ĺ	ath w	rai		IES MEA	ADOW CT.			2115				JSA	
0036 -0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Heatth and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-f show any injury or other traumatic event. The Medical Examinar must be multilast at once.	Be Completed by Funeral Director	11. Marital Status  1 □ Never Marri 3 □ Widowed	ied 2☐ Married 4 ☐ Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	es? █ No	ı	Vas Decedent of Yes, specify Cub ☐ Yes 2 No	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)		4. Race - Amer Black, White Specify: W.I.	
200	72 ho natur	sted	(Snec	15. Decedent's E	ducation		16a. Deced	lent's Usual Occu	pation	tina	16b. Kin	d of Business/I	ndustry
25	ithin ne.	npie	Elementary/Seco		College (1-4	or 5+)	l .		during most of wor	king			
72	iled w Hygiei ther tl	Ö	17. Father's Name	First Middle Last	*1		ASS	SEMBLY		an /First Adiabat		UFACTU	RING
and	d be t	To Be	17. Fallier 3 Hallie		MAS JOHI	N PET	TIS		18. Mother's Nan	IRENE			
デRレメ Maryland	shouling Mind Mind Mind Mind Mind Mind Mind Mind	-	19a. Informant's Na	ame/Relationship (	Type, Print)		19b. Mailin	g Address (Stree	t and Number or Ru				ip Code)
V1	and 2 salth a n 27 is		THOMAS .	J. PETT	IS - FA	THER	5 FA	NNIES M	CEADOW C	T., WE	STMI	NSTER,	MD.21158
S e	of He of He if item		20a. Method of Disp	osition	Removal from Sta	20b. P		sition (Name of natory or other pla		Date		ation - City or T	
Z Ë	Pag Iment tent: I					" MEAL			EM. 4/12	2/06	WES	TMINST	ER, MD
$K(\mathcal{M}_{\mathcal{S}})$ Baltimore,	permit Depar Impor any in		21. Cignature of Tu	X			25	Name and Address	AIN ST.	WEST	MINS	NERAL L'ER. M	HOME D. 21157
			snock, or nea	rallure. List only	plications that cause on each	sed the death n line.	n. Do not ente	er the mode of dyi	ing, such as cardiac	or respiratory	arrest,	,	Approximate Interval 8etween
	Physician /Medical		Immediate Cause ( disease or condition resulting in death)	Final n	a S	PSI	1						Onset and Death
	Examiner		, , , , , , , , , , , , , , , , , , , ,	- (	Due to (or	as a onsequ	uence of):	dia.					. ZI DU(a)
	.5 *	er	Sequentially list con	nditions, mediate	b. Due to (or	as a consequ	uence of):	<u>(                                    </u>					3 09/06
	cuted od ransit	Examiner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events	rlying injury	ASA	Series	rent						weeks
,0	icate be executed physician and s the burial-transit	Exa	resulting in death) L	.ast	Due to (on	as a consequ	uence of):						
68760,	ate by	dica			d								
	ding p	/Me	IF FEMALE:		23c. If yes, outcor	ne of pregna	nev			· · · · · · · · · · · · · · · · · · ·			
P.O. Box	Attanding Physician: The law requires that the death certificate be executed rideath.  crosth. After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burral-transit	Physician/Medical	23b. Was decedent in the past 12 1 Yes 2 9 Unknown	months?	1 Live birth 4 Pregnant 9 Unknown	2 ☐ Fetal at time of de	death 3□	Ectopic pregnanc Other (specify) _	у		23	3d. Date of deliv	very Day Year
	w requires that been signed b should be deta	by P	Part II. Other signifi	cant conditions o	contributing to death	but not resu	ulting in the un	derlying cause giv	ven in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
ord	equire en si ould b	ted	sm	VVI_15.	JU-11		len	2 DI	1311	10	Yes 2	No 3□Pro	babły 4 🗆 Unknown
Division of Vital Records,	: The law r cate has be page 2 sh	Completed								24a. Was auto perfe	psy ormed?	24b. Were autoprior to codeath?	opsy findings available ompletion of cause of 2 \( \text{No} \)
Vita	sician: Th certificate rector, pag	Be	25. Was case referr examiner?		Hospital:			0#	26. Place of Dea				7777
of	Phys r this ral dir	٠ <u>۲</u>	1.2 Yes 2 ☐ I		· 12Inpa		ER/Outpatient 28b. Time of	3 DOA	ner: 4 ☐ Nursing H	ome 5 Res			fy)
o	th. ; After	tion	1 ☑ Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Ir (Month, L	Day Year)	Injury	28c. Injui Wo M 1	rk? Yes 2 □ No	200. Describe	now injury	occurred	
Divisi	el or Attend safter death I Director; A d in by the fi	Certification:	3 Suicide 4 Homicide	6 Could not be determined	e 28e. Place of	Injury - At horetc. (Specify	me, farm, stre	et, factory, office		28f. Location ( City or To	(Street and wn, State)	Number or Rur	ral Route Number,
(3)	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director; A completely filled in by the fu	edicai C	29a. Certifier (Check only one)	1 <b>Ø</b> Certifying Ph 2  Medical Exam	ysician: To the be niner: On the basis and manner	of examinati	wledge, death ion and/or inv	occurred at the tit estigation, in my o	me, date and place, opinion, death occur	and due to the red at the time,	cause(s) a date and p	and manner as solace, and due to	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and	le of certifier				29c. Licens	se number			signed (Month,	Day, Year)
			1	Iner	> hHe	not	to h	2 P/9	135		4/1	3/06	
			30. Name and addre	ss of person who				*	1				
			CHARLES 31. Date filed (Month	HENSGEN		110 Mi		I DR.	WESTMIN	STER,	MD.	21157	
	Stat Registra	-	,	APR 1 (	2006 A	July 3 Gigital	Jak ,	Booker					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item #7, perFit 6834, 4/12/00 II Department of Health and Mental Hygiene

1- For Amend Item#8 per FH 6834 4/10/06 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Physician RUSSEL PRINCE PM 9:50 APRIL 6 2006 HOMAS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Backmore Ut If Under 1 Year If Under 24 Hrs. Hours Min. NIA 5. Social Security Number 6. Sex Baltimore 8. Date of Birth 1933 (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours -28-4809 NORTH CAROLINA 1 M 2□ F 72 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f ehov r than "netural", or iteme 23e or 28a-f ehov the Medical Examination be notified at 1 Yes 2 □ No MARYLAND 10e. Street and Number Directo 10g. Citizen of What Country? USA. AVENUE Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify If Yes, Give Year or Dates: Specify: ģ BLACK 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) al Hygiene. CONSTRUCTION WORKER 6 THGRADE traumatic event, 17. Father's Name (First, Middle, Last) (UNKNOWN) 18. Mother's Name (First, Middle, Maiden Surname) 12 should be fi nend Mental H ' le marked oth LIND 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Foute Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Heelih er
Importent: If Item 27 le
eny Injury or other trau WALTERS DAUGHTEL 5715 G15T AVE.

20b. Place of Disposition (Name of cemetery, crematory or other place) 21215 BALTIMORE MD. JORIENE 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State WOODLAWN CEME 04-12-06 WOODLAWN, MARYLAND 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility ROWN JR. FUNERAL HOME 2140 N. FULTON AVE. BALTO, MD. 21217 21. Signature of Funeral Service Licensee retrich N.V 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Ro Due to (or as a consequence of): **Physician** 20 days disease or condition resulting in death) /Medical Examiner Hypoteusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Failure Heral Acute that initiated events resulting in death) Last Due to (or as a consequence of): ettending physicien Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 9☐ Unknown 5 Other (specify) 9 Hinknown been signed to should be detail 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4. Unknown diabetes funeral director, pege 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Honllation After this certificate has autopsy 1 Yes 2 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ D0A Certification: To 28a. Date of Injury (Month, Day Year) To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funera 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 @Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and titte of certifier RES-6,2006 M.D NOON 30. Name and adcress of person who completed cause of death (Item 23a) (Type, Print) Baltimare EVI Sinai STAVROU

DHMH 17 Rev 1/2001

State

Registrar

homes

21215-0036

Baltimore,

Division of Vital Records, P.O.

"Sheut

Hospital of

M.D

0 2006

32. Refistrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death POWELL Month APRIL **Physician** 01 11-50p.M 2006 /Medical not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. rs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 Director lesidence of Decedent Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland 10b. Count th and Mental Hygiene. 27 is marked other than "naturel", or Iteme 23a or 28a-f ehow traumatic event, the Medical Exactinat must be notified at 10d. Inside City Limits 11 Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 25 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during life OO FOT use retired) 15. Decedent's Education (Specify only highest grade complete 4or 5+) ondary (0-12) Be bnship (Type, Print) Department of Health as importent: If Item 27 is eny injury or other traisons. Method of Disposition Jurial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): **Examiner** NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by EIMER'S DEMGNTIA 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 25 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death [Check only one] 1 SInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 XNo 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 Natural within 24 hours after death. To the Funeral Director: A 2 Accident investigation 1 ☐ Yes 2 ☐ No the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number

State Registrar Lamagnanu

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

mpleted cause of death (Item 23a) (Type, Print)

32. Peristrar's Signature

1

054288

Hourset Horizon

Physician/ Medical Examine

Funeral Director

or items 23a or 28a-f show a must be notified at once.

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoingry or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Baltimore, MD 21215-0036

	State of Mary	land / Depart	ment o			/giene	000	1 1 1 1
l- For State Registrar		Certi	ficate of	f Death		Reg	No. ZUL	Jb IIU
Decedent's Name (First, Michael Control of the	ldle,Last)					Date of Death     Month	Day Year	3. Time of Death
	D. Pilars					April 5, 200		11:30
4a. Facility Name (if not institu Franklin Square Hos	· -	number)		4b. City, Town, or Rosedale	Location of Death		4c. County of De Baltimore (	
5. Social Security Number 215-54-3193	6. Sex	7. Age (In yrs. last	• •	If Under 1 Yea Months Day		8. Date of Birth	(MM/DD/YYYY) 9. 1,1965	Birthplace (State or Fo Country) Marylan
Usual Residence of Decedent 10a. State 10b. Count	y	10c. City, To	wn or Locat	ion				10d. Inside City Lir
Maryland Ba	ltimore Co	) _ M	iddle	River				1 Yes 2 X
10e. Street and Number				10f. Zip Code		100	g. Citizen of What 0	Country?
403 Kosoak I	Road				21220		United S	states
11. Marital Status 1 Never Married 2 X	Married Armed I	2 X No	If Y	es, specify Cuban	panic Origin? ( Sp , Mexican, Puerto		14. Race - Ar White, et	nerican Indian, Black,
	Divorced If Yes, Give Ye or Dates:			Yes 2 X No			Specify:	
15. Decedent's Education (S) Elementary/Secondary (0-1)  12 yrs.			ring	n's Usual Decupat working life. DD N Homemak (	,	ork done	16b. Kind of Busine	Home
17. Father's Name (First, Midd	le. Last)				18.Mother's Name	(First, Middle, Ma		Tione
Richard A.	Soltys				Dolores		arzynski	
19a Informant's Name/Relation	•		19b. Mailing	Address (Stree			er, City or Town, S	tate, Zip Code)
20a Method of Disposition  1 X Burial 2 Cremati 4 Donation 5 Other 21. Signature of Puneral Service 23a. Part I Enter the disease, failure. List only one caus	Specify:  Collicensee Mich	from State cre Dular nael E. Cana	ney Val.	ley Mem. Ga lame and Address Leonard	ardens Apr of Facility J. Ruck,	il 08,20	Baltimore	nium, MD ford Road
Immediate Cause (Final disea or condition resulting in death)	se a. <b>Malnu</b>	trition and a consequence of):	dehydra	ation				Death
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Las	Due to (or as	post multipa consequence of): disease, post a consequence of):						geries
	d.	÷+//00 -	07	ME OF /	/10 /04 1111			
X UNPENDED	AMENDED	item#23a-c	2,2/,pe	ME, g854,4/	/13/06 TT			
F FEMALE: (3b. Was decedent pregnant in past 12 months?  1  Yes 2  No 9 ✓ L	the 1 Live	, outcome of pregnar birth gnant at time of death nown	2 Fe	tal death 3   her (Specify)	Ectopic pregna	псу	23d. Date of deli- Month	very Day Year
Part II. Other significant cond		to death but not resu	ulting in the u	underlying cause g	iven in Part I.			to the cause of death?
						24a. Was an		
						perform 1 Yes 2	ed? death	to completion of cause
25. Was case referred to medic	al			26. Place	of Death (Check of	perform 1 Yes 2	ed? death	
examiner?	cal Hospital: 1 ✔	Inpatient 2 El	R/Outpatient		Othor:	perform 1 Yes 2 only one)	ed? death	to completion of cause n? Yes 2 No
examiner? 1 ✓ Yes 2 No 27. Manner of Death 1 ✓ Natural 5 Pe	Hospital: 1 28a. Date (Mon		R/Outpatient	3 DDA njury 28c. Injur	Other Nursing	perform 1 Yes 2 enly one) g Home 5 R	ed? death No 1	to completion of cause 1? Yes 2 No
examiner? 1 Ves 2 No 27. Manner of Death 1 Natural 5 Pe 2 Accident Inv 3 Suicide 6 Cc 4 Homicide	Hospital: 1 28a, Date (Monitor) ending vestigation	e of Injury 28 th, Day,Year)	Bb. Time of I	3 DDA  njury 28c. Injur	Other Nursing Nursing at Work?	perform 1 Yes 2 inly one) 1 Home 5 R 28d. Describe ho	esidence 6 0  w injury occurred	to completion of cause n? Yes 2 No
examiner? 1 Ves 2 No 27. Manner of Death 1 Natural 5 Pe Accident In 3 Suicide 6 Co de 4 Homicide 29a. Certifier 1 Certifying	Hospital: 1 28a, Date (Monitor) ending vestigation build not be	e of Injury th, Day, Year)  ce of Injury - At home  c)  est of my knowledge, s of examination and	e, farm, stree	3 DDA  njury 28c. Injur  1 \( \)  et, factory, office b	Other 1 Nursing y at Work? /es 2 No uilding, etc.	perform 1 Yes 2 vinly one) g Home 5 R 28d. Describe ho 28f. Location (Str or Town, Sta	esidence 6 0 w injury occurred reet and Number or te)	to completion of caus  Yes 2 N  ther:  Rural Route Number

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760,

> Patricia Aronica-Pollak MD. State Registrar

31. Date filed (Month, Day, Year) APR 1 0 2006

30 Name and address of person who completed cause of death (Item 23a)



Assistant Medical Examiner

**ORIGINAL** 

O.C.M.E

111 Penn Street, Baltimore, MD 21201

April 6, 2006

DHMH 17 Rev 1/2001 OCME 10/2003

DHMH 17 Rev 1/2001

Registrar

aiaia		For State Regist Amend item 1. Decedent's Name (First, Middle, L.	ast)				2. Date of Dea Month	Reg. No. ath Day Year	3. Time of Death
sicia edic			Joseph	Thomas	Rennie, Jr	•	Ц	02 200	610:50 AM
mine		4a. Facility Name (If not institution, gi	·			or Location of Deat	n	4c. County of Dea	ath
		isaltimora V.			day) If Under 1 Year	h more			14
ral tor			Sex 7. Age (	(In yrs. last birth	Months Days		8. Date of Birt (Month, Day Oct. 6,		rthplace (State or Foreign country) aryland
	1	10a. State 10b. County	1	10c. City, Town	or Location				10d. Inside City Limits
COLOR CONTINUES OF THE PROPERTY OF THE PROPERT	to	Maryland Ba	ltimore			Dunda	alk		1 ☐ Yes 2 🛣 No
	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	a	7034 Sollers Po	oint Road			21222		United S	tates
	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1		13. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh Specify:	
	Completed b	15. Decedent's E (Specify only highest gi		16a. D	ecedent's Usual Occup Sive kind of work done	pation during most of wor	rkina	16b. Kind of Business	s/Industry
١	gr.	Elementary/Secondary (0-12)	College (1-4or 5+)	)	Give kind of work done ife. DO NOT use retire	nd)			
		12 Years 17. Father's Name (First, Middle, Las	ne)	<u> </u>	Stimator	10 Matheda No.	- Circh Middle	Roofing (	Company
	Be						a Welch	машеп эитате)	
	၉ .	Joseph T. Re		19h I	Aziling Address (Street			r, City or Town, State,	Zin Codo)
		Mrs. Anna Marie			034 Soller			alk, Maryl	
1	-	20a. Method of Disposition	,	20b. Place of D	isposition (Name of		Date	20c. Location - City o	r Town, State
		12 Burial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Spec		D	<i>crematory or other pla</i> .awn Cemete	1	2006	Marriottsv	ille, MD
1		21. Signature of Fine al Service oc	The July	In .	22. Name and Addre Duda-Ruck 7922 Wise		Home of i	Dundalk, I	nc. 222
		23a. Part . Enter the disease, or cor shock, or heert failure. List only	mplications that caused th						Approximate Interval Between
n	4	Immediate Cause (Final disease or condition	D.	monic					Onset and Death
al er		resulting in death)	Due to (or as a						
ı	- G	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of	:				
1	Examin	Sequentially list conditions, if any, leading to immediate causa. Entar Undarrying Cause (Disease or injury that initiated events							
	Exa	resulting in death) Last	Due to (or as a	consequence of	i.				
	edicai		d						
	/Med	IF FEMALE:	230 If was outcome of	orognanou					
	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes ZONO 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	Fetal death	3 ☐ Ectopic pregnance 5 ☐ Other (specify) _	у		23d. Date of de Month	Day Year
	2	Part II. Other significant conditions	contributing to death but	not resulting in t	he underlying cause gr	ven in Part I.		bacco use contribute t	
	eted						104	es 2□No 3□P	robably 4 donknown
	Completed						24a. Was a autop: perfor 1 Tes	sy prior to death?	utopsy findings available completion of cause of s
ŀ	Be	25. Was case referred to medical examiner?	Hoosital:		1		th (Check only or	19)	
- 14	2	1 Yes 2 No	Hospital: 1 Inpatient		atient 3 DOA			ence 6 Other (Spe	ecify)
	atlon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day )	/ear) 28b. Tin Inji	iry Wo	ryat rk? ∣Yes 2 ∐No	28d. Describe h	ow injury occurred	
	Certification:	3 Suicide 6 Could not to determined		/ - At home, farm (Specify)	street, factory, office		28f. Location (S City or Tow	treet and Number or R n, State)	lural Route Number,
	edical	29a. Certifier Certifying P	hysician: To the best of eminer: On the basis of eminer: and manner state	xamination and/	death occurred at the li	me, date and place opinion, death occu	, and due to the or	ause(s) and manner a late and place, and du	s stated. e to the cause(s)
-1.		29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Mon	th, Dey, Year)
- P	- 1					_		1 1	
		1	DIA		A0417	t6435G1	6747	04/02/7/	206
		30. Name and address of person who	completed cause of dea	ith (Item 23a) (T	(pe, Print)	16435G1	6747	04/02/20	21201 21201 1012, MD

DHMH 17 Rev 1/2001

			1 - State of Ma	ryland / Dep <i>Ce</i>	artment ertificate			nd Me		iene	16	11061
**	Physici /Medi		Decedent's Name (First, Middle, Last)     Beola Smith						2. Date of Deat Month April 6,	Day	Year	3. Time of Death 4:00pm M
	Examir		4a. Facility Name (If not institution, give street and number)  Sandtown Winchester			Ba	Location of D			4c. County		•
7	Funeral Director	3	5. Social Security Number 6. Sex 7. Age 1 M 2 X F	(In yrs. last birthday 93 Yrs.		Days	If Under 24 Hours	Min.	3. Date of Birth (Month, Day, 08-11-19)	Year) 12	Cour	place (State or Foreign htry) h Carolina
	se Maryland Ba-f ehow	Director	10a. State 10b. County MD NA	10c. City, Town or L	ocation Balti	more					1	0d. Inside City Limits 1XXYes 2 □ No
	h with th	ai Dire	10e. Street and Number 2305 Calverton Heights		10f. Zip 0	Code 21216			1	0g. Citizen of US		ntry?
9036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or Items 23a or 28s-f show or other traumatic event, the Medical Examinar must be publised at	d by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 4 Divorced  1 Was Decedent E Amed Forces?  1 Yes 2 No. 17 Yes 2 No. 17 Yes Year or Dates:		Was Decede	fy Cubar	spanic Origin n, Mexican, P Specify:	i? (Speci Puerto Ri	ify Yes or No- can, etc.)	14. Rad	ce - Americ ck, White,	etc.
Maryland 21215-0036	d within 72 h giene. ir than "netu Ine Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+	(Giv	edent's Usual e kind of work DO NOT use Domest	doné d retired)	uring most of	f working	7	16b. Kind of B	omesti	
yland ;	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma	To Be C	17. Father's Name (First, Middle, Last) unknown					,	First, Middle, M McKinnor	Maiden Sumar		
	and 2 shi lealth and m 27 is m		19a. Informant's Name/Relationship (Type, Print)  Tanya Butler/ Granddau hter						Route Number, Intora M		State, Zip	Code)
Baltimore,	Pages 1 announce of He ant: If item ury or other		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)	20b. Place of Disposemetery, cree Mt. ZIon (	osition (Name amatory or oth	e of er place	)	Dat	le :	20c. Location Lansdown		wn, State
<b>Balt</b>	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	W		era1	Home 63		Gilmor S	t. Balto		21217
}	Physician		23a. Part1. Enter the disease, or complications that caused to shock, or heart failure. List only one cause on each line immediate Cause (Final disease or condition	the death. Do not en	oter the mode	of dying	, such as car	rdiac or r	espiratory arre	est,		Approximate Interval Between Onset and Death
a .	/Medical Examiner	iner	Sequentially list conditions.	consequence of):	2d	0	t me	int	_~			
8760,	icate be executed physician and s the burial-transit	dical Examiner	that initiated events c.	consequence of):								
.O. Box 68	eath certif attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic prec □ Other (spec						te of delive	ny Day Year
Records, P.	w requires that the d been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but	not resulting in the u	underlying cau	ise give	n in Part I.		23e. Did tob			e cause of death?
		Completed						_	24a. Was an autopsy perform	ed?	death?	osy findings available inpletion of cause of
Vital	ysiciar is certif directo	To Be	25. Was case referred to medical examiner?  1  Yes 22 No Hospital: 1 Inpatient	t 2 ER/Outpatie	nt 3 DOA	Other			Check only one 5 ☐ Resider		er (Specify	·)
Division of	De fe	Certification:	27. Manna of Death  1 Matural 5 Pending (Month, Day)  2 Accident investigation	Year) 28b. Time o	of 280	injury Work			d. Describe how			
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fu		4 Homicide building, etc.						City or Town,	State)		Route Number,
	the Hose in 24 ho the Fund pletely f	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of a and manner state	xamination and/or in	th occurred at ivestigation, in	the time my opi	e, date and pl nion, death o	lace, and	d due to the car at the time, da	use(s) and ma te and place,	and due to	ated. the cause(s)
}	ot ot other	2	29b. Signature and title of certifier	O- 1 64 A-		License 2	number	010		d. Date signed	d (Month, I	Dey, Year)
			30. Name and address of person who completed cause of dea	ath (Item 23a) (Type,		0.5	- 8		6030	~	1011	21-
100	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar	n D 260 s Signature	facel .	うり	ICIY F	140	s M R	>17ETIM	IOME	mo 21215

	<b></b> .		1 - For State Registrar		Maryland / Dep <i>Ce</i>	artmen ertificat			and M		giene Reg. Nô.		11062
ı	Physic		1. Decedent's Name <i>(First, Middle, L</i> Mary Ann Shacka	ast)						2. Date of De.	ath Day	Year	3. Time of Death
>	/Medi Exami		4a. Facility Name (If not institution, g	ve street and numbe	r)	4b. City,	Town, or	Location o	f Death	11114	4c.	County of Death	1
			Baltimore Whahinaton	Medical Ce	utes	Gur	Bue				A	UNE ARU	MIXEL
	Funeral Director		5. Social Security Number 3 6. 212-60-6143	Sex 7. A 1 M 2 □XF	lge (In yrs. last birthday 53 Yrs.	Months	1 Year Days	Hours 1	Min.	8. Date of Birt (Month, Da	y, Year)		nplace (State or Foreign untry)
			Usual Residence of Decedent	•						02/15/1	.953	Balt	imore, MD
	death with the Maryland ms 23a or 28e-f show	JO.	10a. State 10b. County MD Anne Aru	ndel	10c. City, Town or L Hanover	ocation							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28e-	Director	10e. Street and Number			10f. Zip	Code			-	10g. Citiz	zen of What Cou	
	ath wit	ralD	7627 Bear Forest	Road		210	76					USA	
336	after or Ita	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	(No	Was Deced If Yes, spec		spanic Orig n, Mexican, Specify:	jin? (Spe Puerto	ecify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify: Wh	
2-0		eted	15. Decedent's l (Specify only highest g	Education rade completed)	16a. Dece	edent's Usua kind of wo	al Occupa	tion	of worki	na	16b. Kir	nd of Business/Ir	ndustry
Maryland 21215-0036	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4o	life.	DO NOT us	se retired)	uning most	Or WOTKII			UMBC	
land	buld ba filed Mental Hygi arkad other atic event,	To Be	17. Father's Name <i>(First, Middle, Las</i> Arthur Burdette	t)						(First, Middle, E. She			
Mary	s 1 and 2 should ba f Health and Mental item 27 is markad o other treumatic ev		19a. Informant's Name/Relationship Edward Shacka /							Hanover		Town, State, Zi	ip Code)
Baltimore,	0 = 0		20a. Method of Disposition  1  Burial 2 □ Cremation 3   4 □ Donation 5 □ Other (Spec		20b. Place of Dispo	osition (Nan matory or o	ne of ther place	)	D	ate	20c. Lo	cation - City or T	
Baltin	permit. Pa Departmen Importent: any injury once.		21. Signature of Funeral Service Lice	<del>1130</del> 8	(Fair	2. Name an	d Address	of Facility Tuner	al H		adowr	idge, MI idge Memo	orial Park, IN
8760,	And the burial-transit the buria	dical Examiner	23a. Part1. Enter the disease, of shock or heart failure. List onto immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to ( r a. b. Due to (or a.	s a consequence of): s a consequence of): s a consequence of):	ech	on	Can	nce	_			Approximate Interval Between Onset and Death
.O. Box 6	requires that the death certifica sen signed by the attending ph hould be detach <b>a</b> d for us <b>a</b> as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		2 Fetal death 3	∃Ectopic pre ∃ Other (spe					2:	3d. Date of delive Month	ery Day Year
rds, P	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death	out not resulting in the u	nderlying ca	iuse givei	n in Part I.		23e. Did to		se contribute to to	he cause of death?
Il Records,	The law ate has t page 2 s	Completed					-			24a. Was a autops perfort	sy	prior to co death?	opsy findings available impletion of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Othor			(Check only or			
of	ding h. After fune	atlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date if Inju	ury 28b. Time of	_	Bc. Injury	at Nuis	2	ne 5 🗆 Reside 8d. Describe ho		Other (Specificoccurred	ýy)
Division	i die o	Certification:	3 Suicide 6 Could not be determined	289. Place of in	jury · At home, farm, str tc. (Specify)	eet, factory,	office		2	8f. Location (Si City or Town	reet and n, State)	Number or Rura	al Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one)  1 Certifying Pl 2 Medical Exam	nysician: To the best niner: On the basis o and manner st	of my knowledge, death of examination and/or in- ated.	occurred a	t the time in my opi	, date and nion, death	place, a	nd due to the ca	ause(s) a ate and p	and manner as so place, and due to	tated. o the cause(s)
	To the Within To the comp	M	29b. Signature and title of certifier			29c.	License	number		2	9d. Date	signed (Month,	Day, Year)
•			Tentra	ms		7	) 43	97	7		por	1 3	2206
			31. Date filed (Month, Day, Year)	1. 30/A0	death (Item 23a) (Type.	rint)	len	Bus	nie	· mi	210	Hot.	
	Sta Registr			106 32. Hadish	ars signature	back	•						

06-0	2411
Sin,	Yeon

Please Type or Print in Black Indelible Ink

ı, Y <b>e</b> on		1- For State	State		-	Depa	rtment of	Health and	d Mental H	, 0	Reg. No.	2006	1106
Physicia	n/	Registrar  1. Decedent's Name (First, M	iddle,Last	t)						2. Date of De	eath		3. Time of Death
edical Examii		Yeon Sang S	in							April 8, 2	2006	Year	11:49
)		4a. Facility Name (if not institu		e street and r	number)		4	b. City, Town, or I Baltimore	Location of Dea			c. County of Death	
Funeral Director		5. Social Security Number	6. Se		7. Age		ast birthday)	If Under 1 Year Months Days	+-		Birth (MM		hplace (State or Foreiguntry)
J55(5)		215-63-4554	1x	M 2 F		12	Yrs		!	Febru	ary	11, 1994	Korea
й		Usual Residence of Decedent 10a. State 10b. Cour				10c. City,	Town or Locati	on					10d. Inside City Limits
d how 2	L	Maryland Balt	imoı	60		Cate	onsvill						1 Yes 2 No
ith the Maryland 23a or 28a-f show any n-tified at once.	ector	10e. Street and Number				Catt	NIPATTI	10f. Zip Code			10a Citi	zen of What Cour	
or 2	Öire	5 Keelmill Ct						21220					
s 23a	a	11. Marital Status	•	12. Was De	ecedent E	ver in U.	S. 13. Wa	21228  Decedent of Hisp	nanic Origin? ( 9	Specify Yes or N	Kor	ea. 14. Race - Ameri	can Indian Black
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Tiem 27 is marked other than "natural", or items 23a or 28a-f she reraumatic event, the Medical Examiner must be n-fifted at once	Funeral Dir		Married		Forces?	X No		es, specify Cuban,				White, etc.	odir iridigiri, bidok,
after		3 Widowed 4	Divorced	If Yes, Give Ye or Dates:	ear		1	Yes 2 X No	specify:			Specify: A	sian
hours	Completed by	15. Decedent's Education (S					16a Decedent	's Usual Occupati	on (Give kind of	work done	16b. F	Kind of Business/li	ndustry
36 in 72 nan " lical I	plet	Elementary/Secondary (0-1	12)	College	(1-4 or 5	+)	most of v	orking life. DO NO	OT use retired)				
5-0036 led within 7 Hygiene. other than the Medica	E	6 17. Father's Name (First, Midd	dio Lact)				Stud		9 Matharia Nam	o (First Middle		chool	
filed al Hy sed on	BeC								8.Mother's Nam			Surname)	
D 21215-00; should be filed within and Mental Hygiene. 7 is marked other timatic event, the Med	0 8	Sang Chul Sir 19a. Informant's Name/Relation		ype, Print)			19b. Mailing	Address (Street	Myong it and Number or	Sil Ki Rural Route N		ity or Town, State	Zıp Code)
MD d 2 sho lth and n 27 is numati		Sang Chul Sir	n- fa	ther				lmill Ct					
Sre, Mes I and 2 of Health If item 2		20a. Method of Disposition	_				Place of Disposi rematory or oth	tion (Name of cem	netery,	Date		Location - City or	Town, State
MOre Pages   nent of F ant: If i		1 Burial 2 X Crema	_	Removal	from Stat		tro Cre		Ann	i 12 2	006	Catanari	illo MD
Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		4 Donation 5 Other 21. Signature of Funerancerv		see		rie	22 N	ame and Address	of Facility			Catonsv	•
E De C		my on	1				7.	250 Wash	aufman l ington l	Funeral Blvd.	Home Elkr	e at MMP idge, MD	,INC. 21075
Physician		23a. Part I. Enter the disease, failure. List only one cau			caused th	ne death.	Do not enter th	e mode of dying, s	such as cardiac	or respiratory a	rrest, sho	ock, or heart	Approximate Interva Between Onset and
/Medical Examiner		Immediate Cause (Final disea			ılmona	ry Thro	mboemboli	sm					Death
		or condition resulting in death		Due to (or as			·):						
	ř	Sequentially list conditions, if any, leading to immediate		Nephrotic  Oue to (or as	-		٦٠						
	Examiner	cause. Enter Underlying Cau (Disease or injury that initiate	se			,	,						
pg isi	Exal	events resulting in death) La		Due to (or as	a consec	quence of	):						
0,  be executed sician and ourial - transit	gal	UNPENDED	d.	AMENDED									
o, e be ex ysician burial	edical			7									
Aecords, P.O. Box 6876( The law requires that the death certificate cate has been signed by the attending phypage 2 should be detached for use as the b	Physician/M	IF FEMALE: 23b. Was decedent pregnant in past 12 months?	n the	23c. If yes, 1 Live		e of pregr		al death 3	Ectopic pregr	nancy	230	d. Date of delivery  Month  D	ay Year
th cer trendi	icia		lal.aaa	4 Preg	ınant at ti	me of dea	ath 5 Oth	er (Specify)					
Box ne death of the attented for us	'n		Jnknown	9 Unkr									
ires that the de signed by the	by F	Part II. Other significant con	ditions	contributing	to death	but not re	sulting in the u	nderlying cause gi	ven in Part I.				he cause of death?
S, F puires na sign													ably 4 Unknown
cords,	ple									24a. Was	psy	prior to co	opsy findings available ompletion of cause of
Records, The law requir ficate has been s, page 2 should 1	Completed									1 <b>✓</b> Yes	ormed?	death? o 1 ✔ Ye	s 2 No
	Be	25. Was case referred to medi examiner?	-						of Death (Check	only one)			
= ·= ·= ·=	ျှ	1 ✓ Yes 2 No	Н	ospital: 1	Inpatien		ER/Outpatient		Other Nursi	ing Home 5	Reside	nce 6 Other	
ion of V tending Phys eath. ior: After thi		27. Manner of Death 1 ✓ Natural 5 □ D		28a. Date (Mont	of Injury th, Day,Yea	r)	28b. Time of In			28d. Describe	how inju	iry occurred	
ivisior or Attenc after death Director:	atic	= 3 L P	ending vestigatio	n				1Ye	es 2 No				
Division spital or Attendi hours after death.	Certification:		ould not be etermined	e		ry - At ho	me, farm, street	, factory, office bu	ilding, etc.	28f. Location or Town,		nd Number or Rur	al Route Number, City
	Medical C	29a. Certifier 1 Certifying		On the basis	of exam						` '	d manner as startence, and due to the	
, <u>F</u> §F8	Š	29b. Signature and title of cert	ifier	and manner	Stated.			29c. License	number		29d. E	Date signed (Mon	th, Day, Year)
		Httori / a	on	14 -	121	01	La	O.C.N	1.E.		Apri	19, 2006	
		30. Name and address of pers	on who c	ompleted cau	ise of dea	ath (Item :	23a)	Į.					
		Patricia Aronica-Pol	lak MD	. Assist	tant Me	edical E	xaminer	111 Penn Str	eet, Baltimo	re, MD 2120	01		
Sta	ш	31. Date filed (Month, Day, Yea		,	Ea.	Signatur	L	1					
Registr	ar	APR	1 0	2006	and the same	JYR.	AS.	book					
HMH 17 Rev 1/20 CME 10/2003	01						ORIGINÁL						

DHMH 17 Rev 1/2001 OCME 10/2003

			1 - For State Registrar	State of M		Рера		t of H	ealth a		lental H	ygien Reg. N	1000	11064
ı	Physic	ian	1. Decedent's Name (First, Middle, La Lydia	Catherir	20	Cal	noon	h a a		İ	2. Date of I		ау 2006 <sup>Үөг</sup>	
	/Medi Exami		4a. Facility Name (If not institution, give		16	201	noen.		Location of		April	1	c. County of De	10:30 A M
1	Lxaiiii	iei	Ivy Hall Geriatri						e Riv			1	Baltim	
	Funeral	Г	Social Security Number 6. 8	Sex 7. Ag	e (In yrs. last bin	hday)	If Under Months	1 Year	If Under 2	24 Hrs.	8. Date of E	irth Yaar	9.5	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	I□M 2∏F		Yrs.		Days	Hours	Min.	July 5	191	3 Atl	Lantic City,
	h the Maryland r 28a-f ahow motified at	ctor	Maryland Baltimo	re	10c. City, Town									10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	or 28	Director	10e. Street and Number	_			10f. Zip		-			10g. C	itizen of What	Country?
	s 23e	rai	106 Conestoga Roa			T		2122						USA ·
036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or items 23e or 28e-f ahow event, the Madical Examinar must be notified at	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces?  1 Yes 2 N If Yes, Give Year or Dates:		1	Vas Deced Yes, spec ☐ Yes 2		spanic Orig n, Mexican, Specify:	jin? (Spe , Puerto f	city Yes or N Rican, etc.)	lo-	Black, W.	merican Indian, hite, etc. White
21215-0036	within 72 ho ene. than "natur he Medical i	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5		Deced (Give I life. D	ent's Usua and of wor O NOT us	l Occupat k done du e retired)	tion uring most	of workir	ng	16b. i	Kind of Busines	
121	filed with Hygiene. Ither the		12			Hon	emake						Own Hor	ne
Maryland	should be find Mental Himarked ott	To Be	-	nols						r's Name know	(First, Middl n)	e, Maide	n Sumame)	
Mar	d 2 s th ar t7 ta	0	19a. Informant's Name/Relationship ( Edward Schoenberg	Type, Print) (SON)							<i>i R</i> oute <i>Num</i> arylan		or Town, State	a, Zip Code)
re,	Is 1 and 1 Head Item		20a. Method of Disposition		20b. Place of	Dispos		e of			ate	_	ocation - City	or Town, State
Ē	nit. Page bartment cortant: If injury or		1 Burial 2 Cremation 3 — 4 Donation 5 Other (Specification)	Removal from State  y)	Bayvie		-		1	4/10	/06	Dal	+4rimen	, Maryland
Baltimore,	pernil. Pages 1 an Depentment of Heal Important: If item 2 any injury or other ance.		21. Si nalure of Fun ral Struice Lice	-	人	22.	Name and	Address	ol Facility	Bru	zdzins	ki F	uneral	Home PA and 21221
	Pnysician /Medical		23a. Par 1. Enter the disease, or com sho, or heart failure. List only Immediate ause (Final disease of indition resulting in death)	I TO	chemi	ot ente	r the mode	of dying,	such as c	ardiac or	respiratory	arrest,	raryro	Approximate Interval Between Onset an Teath
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Core	a consequence of consequence of	a	Nev	y	Pis	es	ie !			Un Krum
3ox 68760,	Attending Physician: The law requires that the death certificate be executed or death.  r death.  cotor: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	d			Ectopic pre	gnancy					23d. Date of d	
P.O. Box	et the dea I by the a stached fo	hysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at i 9□ Unknown		5 🗆	Other (spe	city)					Month	Day Year
ords,	w requires th been signed should be d	þ	Part II. Other significant conditions of	ontributing to death bu	Λ	the und	į.	use given	in Part I.	_				to the cause of death?  Probably 4 (Unknown
Division of Vital Records,	hysician: The law i his certificate has be I director, page 2 sh	Completed	25. Was case referred to medical								24a. Was auto perf 1 Yes	psy ormed?_	prior to death?	autopsy lindings available completion of cause of es 2 100
5	ysicia s cert direct	To Be	examiner?	Hospital: 1 ☐ Inpatier	nt 2□ER/Out	ationt	3 DOA	Other			Check only		a Clou	
ion of	Attending Phys death. ctor: After this y the funeral di		27. Manner ol Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day				c. Injury a Work?		28	8d. Describe		6 ☐ Other (Sp ry occurred	ecity)
DIVIS	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, larr (Specify)	n, stree	et, factory,	office		28	Bl. Location ( City or To	Street ar wn, State	nd Number or F	Rural Route Number,
:	he Hospital or n 24 hours afte he Funeral Dir pletely filled in I	Medicai	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	ysician: To the best of iner: On the basis of and manner stat	examination and	death of	occurred at stigation, i	t the time, n my opin	, date and nion, death	place, ar occurred	nd due to the d at the time,	cause(s	) and manner a d place, and du	as stated. ue to the cause(s)
1	To the within 2 To the complet	Σ	29b. Signature and fitle of certifier	0				License r					te signed (Mor	
			30. Name and address of person who d	ompleted cause of de	ath (Item 23a) (T	ype, Pi	rint)	ν <b>-</b> 3	87	54				2006.
	\		MALIKA WASA  31. Date filed (Month, Day, Year)	2BM. 7		A3	TER	N	13LV	D,	M.1	2 -	2/2	21.
	Stat Registra	9	APR 1 0 2006	32. Registra	3 Signature	48	3							

DHMH 17 Rev 1/2001

			for State Registrar	State of Maryla		artment of H rtificate of L			ienė 🛭 🗍	16	11065
			Decedent's Name (First, Middle, La	st)				2. Date of Deat	h	V. 1	3. Time of Death
	Physici		Kenneth Vernon	Stouffer				Month 03	30 200	Year 6	9:30 A <sup>M</sup>
	/Medio Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death		4c. County	of Death	
		٠.	Summit Park			Catonsv	ille		Ba1	timo	re
	Funeral		5. Social Security Number 6. S		rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Yeer)	9. Birthpl Count	ace (State or Foreign
	Director		150-28-0695	X 2 F 66	Yrs.	months Buys	110410	June 5,	1939	Penr	sylvania
	pur *		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				10	d. Inside City Limits
	sho	ŏ									1 ☐ Yes 2 ☑ No
	28a-1	ect	Maryland   Anne Ar	undel Ha	nover	10f. Zip Code		1	0g. Citizen of W	hat Count	try?
	with so a	ă	155 Chesapeake M	obile Ct		2107	6		USA		.,
	ns 23	era	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-	14. Race	- America	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show othar traumatic event, the Medical Exartinating the notified at	by Funeral Director	1 Never Married 2 Married 3 Widowed 4 ☑ Divorced	Armed Forces? 1 ★Yes 2 □ No If Yes, Give Year or Dates: Kor		lf Yes, specify Cuba 1 □ Yes 2 및 No	n, Mexican, Puerto Specify:	Rican, etc.)	Specify:	c, White, e	ite. ite
ŏ	2 hou	Completed by	15. Decedent's E	ducation		dent's Usual Occupa	ation	ina	16b. Kind of Bus	siness/Ind	ustry
215	hin 7	pie	(Specify only highest grant (0-12)	College (1-4or 5+)	life.	DO NOT use retired	)	ing			
	gient gient er th	ГO	12			Bus Drive			Bus Cor		·
pu	d oth	Be (	17. Father's Name (First, Middle, Last	)			18. Mother's Name		Maiden Sumame	e)	
yla	should be filed within ind Mental Hygiene.  marked other than "umatic evant, the Mer	ဥ	(Unknown)				(Unkr				
Maryland	l 2 sho		19a. Informant's Name/Relationship (Robert E. Johnst	** *		ng Address <i>(Street a</i> Chesapeak					
d)	ss 1 and 2 of Health of litem 27 is r othar tra		20a. Method of Disposition	201	. Place of Dispo	sition /Name of	· · ·		20c. Location - (		
Baltimore,	nt of h		1 Durial 2 Cremation 3 □	Removal from State C	cemetery, crei rownsvi	lle Veter Cemetery	ans 4/4/0				Maryland
턆	it. Partime		<ul><li>4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice</li></ul>			2. Name and Addres					
Ba	permit. Pages 1 Department of H Important: If ite any injury or ot once.			7		620 Wilke					
			23a. Part1. Enter the disease, or com	plications that caused the d	eath. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arm	est,		Approximate Interval Between
	Physician		shock, or heart failure. List only Immediate Cause (Final	co (m	Con	c0 -					Onset and Death
7	/Medical		disease or condition resulting in death)	a Due to (or as a cons							
	Examiner		Sequentially list conditions,	b	<u>.</u>						
V	D #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	equence of):						
<i>N</i>	ecute and -trans	cam	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a cons	equence of):						
60,	icate be executed physician and s the burial-transit	dical Examiner		240 10 (01 43 4 00)	oquanos oi).						
98760	phys s the	dic		_ d							
Box (	leath certifi attending I for use as	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre		-			23d. Date	of delive	ry
ă	death certifi e attending id for use as	by Physician/Mo	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of		⊒Ectopic pregnancy ☐ Other <i>(specify)</i>			Mon	th	Day Year
P.0	by the	hys	9 □ Unknown	9□ Unknown							
	law requires that the deatt as been signed by the atte 2 should be detached for	by P	Part II. Other significant conditions	contributing to death but not	resulting in the u	inderlying cause give	en in Part I.	_/			e cause of death?
Records,	w require been si should l							1 <b>2</b> Y	es 2 No	3   Proba	ably 4 Unknown
ecc	lawr as be	Completed						24a. Was a autops	y P	rior to con	sy findings available apletion of cause of
- H	The Tate has page	Son						perform 1 ☐ Yes		eath? Yes	2 No
Vital	cian: ertific ector,	Be	25. Was case referred to Medical examiner?	Liitali		Oth	26. Place of Deat	h (Check only on	e)		
of	Physician: this certific ral director,	2	1 Yes 2 No		ER/Outpatie		4 Privirsing Ho	me 5 Reside			)
	fe fe	lon	27. Manner of Death 1	28a. Date of Injury (Month, Day Year	) Injury	Worl	Yes 2 □ No	Zau. Describe in	W Inquiry occurre	, ,	
isi	Attending it death. actor: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	De Disco of loius. A	t home, farm, st		103 2	28f. Location (Si	reet and Number	er or Rurai	Route Number,
Division	after Dira in by	Certification:	4 Homicide determined	building, etc. (Spe	ecify)			City or Town	n, State)		
	spita nours neral	aic		hysician: To the best of my							
	To the Hospital or Attendii within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	edical	(Check only 2 Medical Exa	miner: On the basis of exam and manner stated.	ination and/or in						
	To t To t	Σ	29b. Signature and title of certifier	2/1/-		29c. Licens	_	_	9d. Date signed		
	,		· Wax 2	5010		D/	>8 10	Κ /	Arch !	30	2006
1	181		30. Name and address of person who	completed cause of death (	tem 23a) (Type,	Print)	58 70 mex.	Pa. 15	Lu .	- >	1176
			31. Date filed (Month, Day, Year)	BUB M O	gna <b>ku</b> ře	active of	ree!	recpe	co an		1150
	Sta Regist		APR 1 0 2	006 Been	Al Page						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	ıryland / I	Departme <i>Certifica</i>			l Mental Hy	giene Reg. No.	006		66
			1. Decedent's Name (First, Middle, Last	)					2. Date of De	ath Day	Year	3. Time of	Death
	Physici /Medio			Lawrence	Alexand	er Schu	ıltz				- 2006	7:00	PM
1	Examin		4a. Facility Name (If not institution, give	street and number)		4b. Ci	ty, Town, or	Location of De			County of Death		
			Franklin Sonu	are Hosi	oital	R	0500	docle		1	Boultin	ore	
	Funeral		5. Social Security Number 6. Se	7. Age	(In yrs. last bi		er 1 Year	If Under 24 H				lace (State o	or Foreign
	Director		213-20-3327	]M 2□F	82	Yrs. Month	s Days	Hours Mi	Nov. 2	8.192		ny) ryland	
	<u> </u>		Usual Residence of Decedent									<u> </u>	
	nylar how	_	10a. State 10b. County		10c. City, Tow	m or Location					1	0d. Inside C	
	e Ma	cto	Maryland Bal	timore				Edgeme	ere			1 🗌 Yes	2 <b>⊠</b> No
	h the	Director	10e. Street and Number			10f. 2	Zip Code			10g. Citiz	en of What Cour	ntry?	
	th will		7843 Denton Ave					21	219	Ū	nited S	tates	
	dee and	by Funerai	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Dec	cedent of His	spanic Origin?	(Specify Yes or No erto Rican, etc.)	)- 1-	4. Race - Americ		
ဖွ	or its	F	1 Never Married 2 Married	1 ☐ Yes 2 ☑ N	0		2 □KNo	Specify:	Bito Ficall, etc.)		Black, White,	etc.	
21215-0036	ral.	by	3 Widowed 4 Divorced	Year or Dates:		1 105	2 100	эрөспу.			Specify:	White	
5	72 h natu	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a	Decedent's Us	sual Occupa	ition furing most of w	vorkina	16b. Kin	d of Business/In	dustry	
21	ithin	ldu	Elementary/Secondary (0-12)	College (1-4or 5	+)	life. DO NOT	use retired)	)					
2	y gier	Ş	6 Years			Open He		Operato			eel Ind	ustry	
밀	a H of H	Be	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Middle	, Maiden S	Sumame)	-	
<u>X</u>	Men Men mrka mrka	2	Thomas Schultz						Theresa	O'Lea	ry		
Maryland	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f ahow aumatic avant, I.a.Maulcal Exambar neual be notified at		19a. Informant's Name/Relationship (Ty		e) 19t	. Mailing Addre	ess (Street a	nd Number or I	Rural Route Numb	er, City or	Town, State, Zip	Code)	
Σ	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  By injury or other traumatic avant, it a Mulical Examplant mental banouffled at ADE.		Mrs. Ruth Ellen	Schultz		7843 D€	nton .	Ave. E	dgemere,	Mary	land 2	1219	
Ze	of He		20a. Method of Disposition		20b. Place o cemete	f Disposition (N	iame of r other place	<b>)</b>	Date	20c. Loc	ation - City or To	wn, State	
Ĕ	Page nent nt: If ry o		1   Burial 2 □ Cremation 3 □ F  Donation 5 □ Other (Specify)	emoval from State		-		dns. 4/	7/2006	Mi	ddle Ri	vor M	(I)
Baltimore,	mit.		21. Signature of Fineral Service Licens		17	22. Name	and Address	s of Facility					ID
ä	Ped in a		Troops 1	1 to	X	Duda-	Ruck .	Funeral	Home of	Dund	alk, In	C.	
			23a. Part1. Enter the gisease, or compl	cations that caused	the death. Do				undalk, I		and 21	Approximat	e
	Observatoria de		shock, or heart fallure. List only or Immediate Cause (Final			<u> </u>						Interval Bet Onset and I	ween Death
)	Physician /Medical		disease or condition resulting in death)	Kespir	consequence	1 tail	Mre					· · · -	-
	Examiner			3		-							
		9	Sequentially list conditions,	Dug to for as a	Source Control	off:							
H	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	,	•								
7	al-tra	xai	that initiated events resulting in death) Last	Due to (or as a	consequence	of):							
68760,	ficate be executed physicien and is the burial-transit	aiE											
	cate phys s the	dicai								_			_
×	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use as	Me	IF FEMALE:	3c. If yes, outcome of	of pregnancy	S				0.5	and Dana and whatever		
Вох	atter for u	Physician/M	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	Fetal death	3 □Ectopic 5 □ Other				23	3d. Date of delive Month		Year
P.O.	the d	ysk	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	in a death	3 Li Ottier (	sp <del>o</del> city)						
۵.	hat t		Part II. Other significant conditions cor	tributing to death bu	t not resulting i	n the underlying	Callse dive	o in Part I	23a Didit	obacco us	e contribute to the	e cause of d	leath?
Division of Vital Records,	w requires that been signed t should be det	þ	~ · · · · ·	re A-	trin			ation		Yes 2			Unknown
5	requ houk	Completed	C O	, , ,	1119	1 1-1 47	71110	CITON		103 2			
ec	iaw nasb	d d	C0(2)						24a. Was	osy		psy findings a	available ause of
	Physician: The lav this certificate has at director, page 2:	5							perfd 1 ☐ Yes	2 No	death?	2 No	
<u>=</u>	Attanding Physician: r death. ector: After this certifice by the funeral director, f	Be	25. Was case referred to medical examiner?				- 0-0	26. Place of D	eath Check only	one			
<u> </u>	ysic dire	2	1 Yes 2 No	lospital: Inpatier	nt 2 🗆 ER/Ou	itpatient 3 1	Othe Othe	4 🗆 Nursing	Home 5 ☐ Resi	dence 6	Other (Specify	1)	
0	fert nera		27. Manner of Death  1. ☑ Natural 5 ☐ Pending	28a. Date of Injun (Month, Day		Time of njury	28c. Injury Work	at	28d. Describe	how injury	occurred		
<u>ō</u> :	ath.	atic	2 ☐ Accident investigation			М		es 2□No					
S S	Pr de	뜵	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, fa	rm, street, facto	ory, office		28f. Location (		Number or Rura	l Route Num	ber,
٥	To the Hospital or Attending Ph within 24 hours eiter death. To the Funerel Director: After th completely filled in by the funeral	Certification:		Dunging, att.	(Cpoony)				0.07 01 701	, Sidle)			
·	hour In fill	Sal	29a. Certifier Check only 2 Medical Exami	sician: To the best o	f my knowledge	e, death occurre	ed at the time	e, date and place	ce, and due to the	cause(s) a	ind manner as st	ated.	
	ha H n 24 he Fi	edical	(Check only 2 Medical Examination)	and manner stat	ed.	cvor investigation	on, in my opi	inion, death oc	curred at the time,	date and p	place, and due to	the cause(s	)
	To the Comp	Σ	29b. Signature and title of eartifler			2	9c. License	number		29d. Date	signed (Month,	Day, Year)	
)			13Mal	B. KIE	LIMO	17	Rec	0000		(9/1)	-04-	2006	
	10		30. Name and address of person who co	mpleted cause of de	ath (Item 23a)	(Type, Print)							J
	W		Dr. Brendan Kiel, 9	000 Frankl	in San	Lave Dr	ive.	Baltin	nore M	7). 2	1237		
	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	r's Signature	1	· · · · · ·	J1 - 111	, , , , , , ,				
3.	Registr		ΔPR 1 0 200	6	A. A.	Constall	,						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April 8, 2006 **Physician** 6:45 am Schmitz Carmela Violetta /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 2525 Pot Spring Rd. L-616 Timonium If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth April Day Year 1922 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 💢 F 84 Mary land 219-01-8582 Yrs Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. Count 10d. Inside City Limits or 28a-1 show the Medical Examiner must be notified at Md. Timonium Baltimore 1 Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21093 2525 Pot Spring Rd. L-616 USA , or Items 23a Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status e filed within 72 hours after dat Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No White þ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Printing permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygient Important: If Item 27 is marked other that any julyry or other traumatic event, that gongs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Vincent DiMaggio Mary Fasanella 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 30 Constantine Dr. Phoenix, Md. 21131 Mr. Joseph Schmitz/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Most Holy Redeemer 1 XBurial 2 Cremation 3 Removal from State 4-12-06 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of neral Service Licensel <sup>22. Name and Address of Facility</sup> Funeral Home, 1050 York Rd. Towson, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician ongestiv Weeks /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The faw requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) be detached Records, P.O. the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ď 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 Yes 2 X No 1□ Yes 2. No Division of Vital To the Hospital or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 10 32. Registrar's Signature 31. Date filed (Mo State 2006

Registrar

Registrar

111 Penn Street, Baltimore, Maryland 21201

30. Name and address of person who completed cause . d ath (Item 23a) (Type, Print)

32. Registrar's Signature

THEODERE

0 2006

31. Date filed (Month, Day, Year)

	1 - State Registrer		Black Indelity Of TT Of Department Certific	ate of Death		Reg. No.	000	11002		
Physician /Medical	1. Decedent's Name (First, Middle, Las Valerie A. S	Sowell			2. Date of De Month March	31	Year 2006	3. Time of Death 12:44 P M		
Examiner	4a. Facility Name (If not institution, give 404 Gwynn Avenue			ity, Town, or Location of De Baltimore der 1 Year   If Under 24 H			ounty of Death	1		
Funeral Director	5. Social Security Number 6. S 218-44-5284 1			hs Days Hours M		47	MD Sinn	place (State or Foreign intry)		
death with the Maryland ma 23s or 28s-1 show rmust be notified at	10a. State 10b. County MD		ty, Town or Location					10d. Inside City Limits 1XX es 2 □ No		
after death with the Maryla or itame 23s or 28s-1 shouning must be notified at	10e. Street and Number 404 Gwynn Aver	nue	10f.	Zip Code 21229		10g. Citizen of What Country? U.S.A.				
or its	11. Marital Status  1 XNever Married 2 Married 3 Widowed 4 Divorced	.S. 13. Was De If Yes, :	14. Race - American Indian, Black, White, etc.  Specify: Black							
d other then "natural", event, the Madical Exe Seed Back Back Back Back Back Back Back Back					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Teacher Aide					
arked other than alic event, the Marin To Be Compl	17. Father's Name (First, Middle, Last) John W. Sowel		Teach	18. Mother's N	lame (First, Middle ret Sow	a. Maiden S	ic Sch			
or resum and mental refitem 27 is marked of r other traumatic ever	19a. Informant's Name/Relationship (	Type, Print)	1	ess (Street and Number or ewood St.		oer, City or		p Code)		
Important: if item eny injury or othe once.	20a. Method of Disposition 1	Removal from State	Place of Disposition ( cemetery, crematory butus Me	Name of or other place)	Date 8 - 0 6	Arbu	ation - City or T tus , MD	)		
importa eny inju poce.	21. Signature of Euneral Service Licensee  22. Name and Address of Facility Wesley Chavis, Jr. Fill 2007 Eastern Ave. Balto.MD 21231									
sician edical aminer	23a. Part. Enter the disease for comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Atherosclerot:  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect  Due to (or as a consect	ic cardiovas					Approximate Interval Between Onsel and Death		
rial -	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):							
d by the attending physicilelached for use as the bu	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	W(t	23d. Date of delivery  Month Day Year							
8 g 2	Part II. Other significant conditions of		23e. Did tobacco use contribute to the cause 1 Probably 4		the cause of death?					
certificate has been si irector, page 2 should be Be Completed					24a. Wa auro Deri Yes	s an opsy formed? 2 \( \sum \) No	24b. Were aut prior to death?	topsy findings available ompletion of cause of		
this certifical al director,	25. Was case referred to medical examiner?  26. Place of Death (Check only one)									
ther I	27. Manner of Death 1   Matural   5   Pending investigation   2   Accident   5   Could not be   3   Suicide   6   Could not be   3   Suicide   5   Suicide   6   Could not be   3   Suicide   5									
rai Direct lled in by	4 Homicide determined building, etc. (Specify)									
within 24 hours after death.  To the Funeral Director: A completely filled in by the funeral Certification Medical Certification	(Check only 2 X Medical Exam	niner: On the best of my kn miner: On the basis of examinand manner stated.	owledge, death occur ation and/or investiga	red at the time, date and plation, in my opinion, death o	ace, and due to the ccurred at the time	, date and p	olace, and due	to the cause(s)		
within To the comple	29b. Signature and title of certifier	V		O.C.M.E.			L 01, 2			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Dav Month Year homas 1130AM 27-2006 Κo /Medical tebruary Facility Name (If not institution, give street and number) c. County of Death 4a 4b. City, Town, or Location of Death Examiner andallst orthW HOSP 2 NONO Bal Kandallstou 0 imore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 6. Sex Birthplace (State or Foreign Country) 1**X**M 2□ F Days Months Min Hours 216-24 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City Jown or Location 10d. Inside City Limits 7 is marked other than "natural", or Itams 23a or 28a-f shov traumatic event, It a Madical Examinar must be notiliad at 1 Yes 2 No Director more 10f. Zip Code 10g. Citizen of What Country? 21208 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ✓ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married Married 1 ☐ Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired 16b. Kind of Business/Industry (Specify only highest grade completed Elementary/Secondary (0-12) Gellege (1-4or 5+) 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be /homais 9a. Informant's Name/Relationship (Type, 19b. Mailing Address Number, City or Town, State, Zip Code) 21208 20a. Method of Disposition 20b. Place of Disposit 20c. Location - City or Town, State 1 Burial 2 remation 3 Removal from State ö permit. Page Department of Important: If any injury or once. \* 4 □ Donayio altimore, 5 ☐ Other (Specify) 21. Signature of Fune 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Intra-crani disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) CERTIFICATION APPROVED BY MEDICAL EXAMINER burial-transit Due to (or as a consequence of): Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 4☐Pregnant at time of death Day 5 Other (specify) detached

**Physician** /Medical **Examiner** 

attending physician

the

à

page 2 s has

this

After

death.

after death

thin 24 hours a

2

within 2

2

Completed

Be

٩

Certification:

Medical

28a-f show

and Mental Hygiene.

If Item 27

should be and Mental

Pages 1

Maryland 21215-0036

Saltimore,

68760

Box

P.0.

Records,

of Vital

Division

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 □XYes <del>2/21/10</del> 28b. Time of Injury

1 ☐ Yes 2 ☐ No 1 Yes 2 No Lacute 26. Place of Death Check onl one) 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify)

autopsy performed?

27. Manner of Death 28a. Date of Injury (Month, Day Year) 5 Pending 2 Accident 02/10/2006 investigation

28c. Injury at Work? 1 ☐ Yes 2 No Unknown

OUVT

28d. Describe how injury occurred Driver in auto/fixed object

6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide road

28f. Location (Street and Number or Rural Rout Lineact City or Town, State) Unknown, Maryland

29b. Signature and title of certifier

29a. Certifier

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Koad

29d. Date signed (Month, Day, Year)

a um me completed cause of death (Item 23a) (Type, Print) 30. Name and address of erson w

62912

Other:

bruary 272006

State Registrar

31. Date filed (Month, Day, Year) APR 1 0 2006

Please Type of Print in Black indelible link		
State of Maryland / Department of Health and Mental Hygiene		
Certificate of Death	Reg. No.	

Vilkerson, Kay	1- For State	itate of Maryl			Health and	Mental Hy		g. No. 2111	6 1107	
Physician/	Registrar  1. Decedent's Name (First, Mid	die,Last)					2. Date of Death Month	Day Year	3. Time of Death	
Medical Examiner							April 4, 200		15:15	
	4a. Facility Name (if not institut Harbor Hospital Cen		umber)		b. City, Town, or L Baltimore	ocation of Death				
Funeral	5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth	n (MM/DD/YYYY) 9.	Birthplace (State or Foreign Country)	
Director	217-40-1939	1 M 2 X F		65 Yrs.			08-06-1	.940	Maryland	
any	Usual Residence of Decedent  10a State 10b. Count	v	10c. City,	Town or Locati	on				10d Inside City Limits	
ž.	MD N			Baltimor	re				1 X Yes 2 No	
the Maryland a or 28a-f sh tified at once Director	10e. Street and Number		1		10f. Zip Code		10	g Citizen of What C	ountry?	
the M. Iffied Dire	3520 Round Road				2122	5		USA		
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 33a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11 Marital Status 1 Never Married 2 X	Married Armed	2 X No	S. 13. Wa	s Decedent of Hisp es, specify Cuban, Yes 2 X No	Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - An White, etc		
s after rral", niner	3 Vildowed 4 LL	Divorced If Yes, Give Y or Dates:		16a Deceden	Yes 2 A No it's Usual Occupation		work done	16b. Kind of Busine	Black ss/Industry	
5-0036 ed within 72 hour lygiene other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			during most of working life. DO NOT use retired)  Nurse				Healthcar	e e	
5-00 ad with ygien other he Me	17. Father's Name (First, Midd	le, Last)				8.Mother's Name	(First, Middle, M			
21215-0036 ould be filed within 7 d Mental Hygiene s marked other than ite event, the Medica To Be Comple	James Barksdale  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Name Address)					F and Number or t	Frances Mae White  Number or Rural Route Number, City or Town, State, Zip Code)			
Baltimore, MD permit. Pages I and 2 sho permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	Darius Wilkerso 20a. Method of Disposition 1 X Burial 2 Cremat				Westhills sition (Name of cem her place)		imore, MD	21229 20c. Location - City	or Town, State	
MOI Pages rent of int: Il	4 Donation 5 Other		nom otate	ng Memori		04-	13-06	Randallsto	wn, MD	
alti mit. spartm sports sports	21. Signature of Funeral Servi		+	22. 1	Name and Address	-			_	
Physician	23a. Part I. Enter the disease, failure. List only one cau	or complications that	caused the death	. Do not enter t	lie Funeral he mode of dying,	Home 638 such as cardiac o	N. Gilmon	r Street Bal est, shock, or heart	to, MD 21217 Approximate Interval Between Onset and	
/Medical Examiner	Immediate Cause (Final disea or condition resulting in death	a. Atherosci ) Due to (or as	erotic Cardiov s a consequence of		ease				Death	
ted Innsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cau	se	s a consequence o	of):						
d sit	(Disease or injury that initiate events resulting in death) La:	Due to (or as	s a consequence	of):						
be executed sician and urial - transit edical Executed	LIMBENDED	d AMENDE	D							
0, e be ev ysician burial	UNPENDED	AMENDE		20000				23d. Date of deli	verv	
the death certificate by the attending physiched for use as the buy.	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1									
cords, P.O. Box law requires that the death has been signed by the att 2.2 should be detached for	Part II. Other significant con	9011	known g to death but not	resulting in the	underlying cause g	given in Part I.	23e. Did to	bacco use contribut	e to the cause of death?	
P.O. s that s that e deta	End Stage Renal [	-					1 Yes	s 2 No 3	Probably 4 🗸 Unknown	
ds, equire een sip ould b							24a. Was		e autopsy findings available to completion of cause of	
Records, 1 The law require: ficate has been significate has been significate has been significate dead by							autop perfo 1 ✔ Yes	rmed? deat		
Vital Rec ysician: The l his certificate I director, page	25. Was case referred to med	lical			26.Place	of Death (Check		2 110	100 2 10	
Vital hysician: this certi	examiner?	Hospital: 1	Inpatient 2	ER/Outpatier			ing Home 5	Residence 6	Other:	
ing Ph After t funeral	27. Manner of Death  1 Natural 5	enung	ate of Injury onth, Day,Year) OWN	28b. Time of Unknown		ry at Work? Yes 2 No	28d. Describe	how injury occurred		
Division of Hospital or Attending 24 hours after death 25 femeral Director: After letter filled in by the function of Cottlification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc.						28f. Location (Street and Number or Rural Route Number, City or Town, State)			
D  To the Hospital within 24 hours. To the Funeral completely filled	= 29a. Certifier 1 Certifying	g Physician: To the Examiner:On the bas and manne	sis of examination	dge, death occi and/or investig.	urred at the time, dation, in my opinion	ate and place, an n, death occurred	nd due to the caus at the time, date	se(s) and manner as and place, and due	started to the cause(s)	
F 2 2 2 3	29b Signature and title of cel				29c. Licens				(Month, Day, Year)	
	30. Name and address of per	Lewy son who completed of	ause of death (Ite		O.C.			April 5, 2006		
	Laron Locke MD.	Assistant Med	ical Examiner	111 Pen	n Street, Baltin	more, MD 21	201			
Stat Registra		0 2006 32.	Registrar's Signa	ature	and					
DHMH 17 Rev 1/200 OCME 10/2003	01	•		ORIGIN	AL					

			1 - For State Registrar	State of Marylar	•	nt of Health and	Mental Hygier	11111	1072		
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Las Q + 4 A A A A A A A A A A A A A A A A A A	relee G	wendoly, Rd. 46. Cit	y. Town, or Location of Deat	APRIL	Day Year 2006 4c. County of Death $\sim$ 1 A	3. Time of Death 5.554 M		
<i>S</i> .	Funeral Director		5. Social Security Number 6. S. 220-34-7207 1  Usual Residence of Decedent	T. Age (In yrs.	8 Yrs. Months	er 1 Year If Under 24 Hrs s Days Hours Min.	8. Date of Birth (Month, Day, Ye		place (State or Foreign htty)		
	e Maryland ta-f ehow	ctor	10a. State 10b. County Baltime	ore Gw	ty, Town or Location  Ynn Oak			1	10d. Inside City Limits		
	23a or 26	Funeral Director	3218 Blue H	ill	10f. Z	ip Code 1207		Citizen of What Cour	ntry?		
5-0036	72 hours atter death with the Maryland natural; or Items 23a or 28s-1 ehow dical Ezantinar must be notified at	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, sp	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: B/			
2121	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryla Department of Health and Mental Hyglene. Importants if item 27 is marked other than "natural; or items 23a or 28a-1 ehove may highly or other traumatic event, the Medical Examinat must be notified at any injury or other traumatic event, the Medical Examinat must be notified at angle.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		16a. Decedent's Us (Give kind of w life, DO NOT TEACHER	vork done during most of wo use retired) Assistant	Si		dustry IS tem		
Maryland	should be fill not Mental H in marked oth	To Be	7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame) 18. Mother's Name (First, Middle, Maiden Sumame)								
-	1 and 2 sho Health and em 27 is mu ther trauma		Antoinette Dub	OSE - daughte	R100 KW		ect. Dun	dalk, mo	21222		
Baltimore,	Pages 1 ment of H ant: if iter		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from State	Place of Disposition (No cometery, crematory of CTEMU	ame of other place)	1	tons Ville,	MO		
Ball	permit. Departminimports eny inju		21. Signatur Fundal Service	Those	gary f	and Address of Fadlity  March F/H 27	Fredhilton	Pass Balt	2/270 0, MD		
TO BEAT	Physician /Medical Examiner	ılner	23a. Flant. Exfor the disease, or core shock or heart failure. List only Immediate Cause (Final diseas, or condition result, g in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a and stone	Endome	etriol Cance	c or respiratory arrest,		Approximate Interval Between Onset and Death		
8760,	sate be executed obysicien and the burial-transit	lical Examiner	that initiated events resulting in death) Last	c.  Due to (or as a consect d.	quence of);						
.O. Box 68	ath certific titending p or use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o	al death 3 Ectopic			23d. Date of deliver	ery Day Year		
rds, P	quires that the de n signed by the a uld be detached f	þ	Part II. Other significant conditions c	ontributing to death but not res	sulting in the underlying	cause given in Part I.		co use contribute to t	he cause of death?		
al Records,		Completed		24a. Was an autopsy performed? 1 □ Yes 2 ☑				prior to co	opsy findings available impletion of cause of		
Vital	Physician: Th r this certiticate ral director, pag	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatient 3 ☐ [	Other	ath Check only one		4.)		
on of	ding Phy h. Atter this tuneral d	tion: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in		79)		
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: Atter this certific completely tilled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined					et and Number or Rural Route Number, State)			
	Hospi 24 hou Funer tely till	Medical	29a. Certifier 1 Certifying Ph	ysician: To the best of my knowner: On the basis of examination	owledge, death occurre ation and/or investigation	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause arred at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)		
	To the Hospital of within 24 hours af To the Funeral D or mpletely tilled in	Mec	29b. Signature and title of certifier	and manner stated.		9c. License number		Date signed (Month,			
_			> tourl	aller		D389 70	2 4,	110/06			
( <u>1</u>			30 Name and addre of person who	completed cause of death (Iter	m 23a) (Typ - P int	w oruth	wille	mal	21093		
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 0 20	32. Degistrar's Sign	ature Accept						

			1 - For State Registrar	State of M	arylan	•	artmen tificate			ind Me	ental Hy	giene Reg. Nö.	006	11073
	Physici	an	Decedent's Name (First, Middle, Las								2. Date of Di		Year	3. Time of Death
	/Medic	al	Mary Catherine Wil								April	<del></del>	006 Year	3:16 A M
4	Examir	ier	4a. Facility Name (If not institution, give 1704 Langley Road	street and number)			4b. City,		Location of	f Death		1	County of De: Baltim	
	Funeral Director		Social Security Number 6. Se	7. Ag	e (In yrs. 85	last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	B. Date of Bi	rth	9. Bi	nthplace (State or Foreign
	ъ		Usual Residence of Decedent							Į.	lan. 1	9,192	, i Mar	yland
	anylan show		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Ba-f	ecto	Maryland Baltimor	e	Esse	ex	T :							1 ☐ Yes 2 QNo
	with t	Funeral Director	10e. Street and Number				10f. Zip						zen of What C	ountry?
	Jeath Tra 23	era	1704 Langley Road	12. Was Decedent	Ever in U	.S. 13. V			spanic Orig	in? (Spec	ify Yes or Nican, etc.)		4. Race - Am	erican Indian,
9	or Ita		1 Never Married 2 Married	Armed Forces?	Vo.	1	fYes,spec 1□Yes 2		n, Mexican, Specify:	, Puerto R	ican, etc.)		Black, Wh	ite, etc.
9	72 hours after death with the Maryland natural', or Itama 23a or 28a-f show acal Examinat navat be notified at	d by	3℃Widowed 4 □ Divorced	If Yes, Give Year or Dates:									Specify: W	hite
15	n 72	Completed by	15. Decedent's Edi (Specify only highest grad	de completed)		16a, Deced	ient's Usua kind of wor DO NOT us	k done di	urina most	of workin	g	16b. Kir	nd of Business	s/Industry
212	y with	ошь	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Homema						Own	Home	
Pu	ai Hyg I otha	Bec	17. Father's Name (First, Middle, Last)						18. Mother	r's Name	First, Middle	, Maiden	Sumame)	
yla	Ment Ment arkec	To	David Eline Reams								e Joh			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heatth and Mental Hygiene. Important: if Itam 27 ia marked othar than "natural", or Itama 23a or 28a-1 show any injury or other traumatic avent, the Marcical Examiter must be notified at once.		19a. Informant's Name/Relationship (T. Sharon Grout (Daug				_						Town, State, 'yland	
re,	tam of Hea ftam other		20a. Method of Disposition	· · · · · · · · ·	20b. P	Place of Dispo emetery, cren	sition (Nan	ne of ther place	1	Da	ite	20c. Lo	cation - City o	r Town, State
Ē	Page nent cant: if ant: if ury or		1  ☐Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)			rdens (	-			ril	10,200	6 Bal	timore	, Maryland
Baltimore,	permit. Depertr Imports any injudence.		21 Signifule of Fundral Service License	100		22	. Name an	d Address	s of Eacility	nski	Funer	al Ho	me, P.	A yland 21221
	₹0 E € Ø		23a. Part1 Edier the disease, or comp	D. Alexandra	>								x, Mar	yland 21221 Approximate
	Physician /Medical Examiner		shoof or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	men	tia		o or dying		Stronge of	TOSPITATORY E			Interval Between Onset and Death
, O	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as										
68760,	rtificate be ng physicii as the bu	Aedical		d			-							
P.O. Box	The law requires that the death certificate be executed ate hes been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 55 No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	Ideath 3□	Ectopic pro Other (spe					2	3d. Date of de Month	olivery Day Year
	w requires that the de been signed by the a should be detached t	by	Part II. Other significant conditions co	,				ause give	n in Part I.				,	o the cause of death? Probably 4 Unknown
Records,	fhe law requ te hes been age 2 shoul	Completed			·					_		psy ormed?	prior to death?	utopsy findings available completion of cause of
ital	ician: Th certificete rector, pag	BeC	25. Was case referred to medical examiner?					N 97	26. Place	of Death	1 ☐ Yes Check only	2 <b>X</b> No	1 10	5 2 NO
of Vital	Physician: The r this certificete he ral director, page	70	1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ Inpatie		ER/Outpatien			4   Nur	sing Hom	e 5 Res	idence 6	☐Other (Sp	ecify)
S C	ing P	ion;	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry y Ye <i>ar</i> )	28b. Time of Injury		Bc. Injury Work			d. Describe	how injury	occurred	
Division	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	ury - At ho	ome, farm, stre	eet, factory		es 2□N			Street and	1 Number or F	lural Route Number,
	pital c		29a. Certifier 1 Certifying Phy						4					
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only one)	rsician: To the best of iner: On the basis of and manner sta	examina	tion and/or inv	estigation,	in my opi	e, date and inion, death	place, ar	d due to the	date and	and manner a place, and du	e to the cause(s)
<b>)</b>	To t	W	29b. Signature and title of certifier	ua V	au	ul	<b>1</b> 0 29c.	License	number 32	38	31	29d. Date	signed (Mon	2006
	P		30. Name and address of person who c	ompleted cause of d	eath (Item	23a) (Type, 1	Prioti	oloh.	D.	1#	304	Balt	al 7,	MN 21237
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 0 200	32 Registra	ar's Signa	ture	des	HIVE	7 /	/\ <u>"</u>				

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of M		d / Depa	artment		th and M			006	11074
	Physici	an	Decedent's Name (First, Middle	, Last)			1	1		2. Date of Dea Month	th Day	Year	3. Time of Death
*	/Medic	al	MQRIE  4a. Fecility Neme (If not institution,		-1			TKMA		APRIL	6	2006	1505 M
	Examin	er	THE JOHNS HO	. 1	" PITAL			own, or Locat		U	4c. Co	unty of Death	
	Funeral		5. Social Security Number			last birthday)	If Under 1	Year If Ur	nder 24 Hrs.	8. Date of Birth	1	9. Birthp	place (State or Foreign
	Director		086-12-8390	1□M 3€7F	10	)2 Yrs.	Months	Days Hou		(Month, Day March 1	4, 190 4, 190	Cour	sissippi
	pu .		Usuel Residence of Decedent  10a. State 10b. County		100 Cit	y, Town or Lo	antina						
	aho a ho	5			_		Cation						0d. Inside City Limits 1 ☐ Yes 2 🗷 🔥
	28a-1	ect	Maryland Baltim	ore	Esse	X	10f. Zip (	Code		- 1	On Citizen	of What Cour	
	3a or	Funeral Director	1925 Middleboro	ugh Road				1221					, .
	death ma 2	Dera	11. Marital Status	12. Was Deceden	t Ever in U	.S.   13.			Origin? (Sp	ecify Yes or No- Rican, etc.)	U.S.	Race - Americ	
9	after or Its	E.	1 Never Married 2 Marrie	Armed Forces  1 Yes 25  If Yes, Give	₹No	į	rres, speci 1 □ Yes 2]			Hican, etc.)		Black, White,	etc.
215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itama 23e or 28e-f ahow fra Madical Exprimer must be midified at	d by	3 ⊠Widowed 4 □ Divorced	Year or Dates	:				cny.		Зр	ecify: Whi	te
5	n 72 i	Completed	15. Decedent (Specify only highes	s Education ! grade completed)		(Give	dent's Usual kind of work DO NOT use	done durina	most of work	ing	16b. Kind	of Business/In	dustry
212	iene. iene. rthen	mo	Elementary/Secondary (0-12) Unknown	College (1-4or		Homema		7 01.1 007			Own	Home	
	illed Hygi other	Be C	17. Father's Name (First, Middle, L	.ast)				18. M	lother's Name	e (First, Middle,			
<u>Ja</u>	should be and Mental a marked c umatic ave	ToE	Casimir Reynold	S				Jo	osephi:	ne Engel	lhart		
Maryland	2 sho and la mu		19a. Informant's Name/Relationsh							al Route Number			
	s 1 and if Health item 27 other t	8	Lillian Schmidt  20a. Method of Disposition	(Sister)	20h B	1 Ham				Baltimor Date			
Baltimore,	Pages nent of h int: If ite		1XXBurial 2 Cremation		е   с	emetery, crer	natory or oth	rer place)	1			ion - City or To	
	integrated in		4 ☐ Donation 5 ☐ Other (Sp. 21. Signalure of Ineral Pervice L		HOI	77 HIT	L Mem.	Address of F	April	10,2006	Balt	imore,	Maryland
R	Pen Pen Pund Pund Pund Pund Pund Pund Pund Pun	(	1000			1	407 o	Bruzo	dzinsk	i Funera	l Hon	me, P.A	and 21221
			23a. Part. Enter the disease, or on shack, or heart failure. List of	complications that cause	ed the deat							Maryı	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	SEF									Onset and Death  2 days
	/Medical Examiner		resulting in death)	Due to (or a	s a conseq								
	LAdillilei	-	Sequentially list conditions,	b. PNE	MOM								4 days 6 Months
/	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			,	م <del>د</del> ( ا	laskai		Palliant	,		6 Months
<u>,</u>	te be executed ysician and ie burial-transit	Exal	that initiated events resulting in death) Last	c. Due to (or a	pesn = s	uence f):	OF U	INTINO	WILL	RIMARY		_	Q1-1010171S
760	ate be executed hysician and the burial-transit	cal		d									
9	certifica nding ph use as th		IF FEMALE:			-							
X R R	death ce e attandi ed for use	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	2 Feta	death 3	Ectopic pre	gnancy			23d	Date of delive	ory Day Year
o O	the de	by Physician/Med	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant : 9□ Unknown	at time of d	eath 5□	Other (spec	cify)			ŀ	Wichter	, , , , , , , , , , , , , , , , , , ,
1	that the ded by detac	Ph	Part II. Other significant condition	ns contributing to death	but not resi	ulting in the ur	nderlying cau	use given in P	art I.	23e. Did to	bacco use	contribute to the	ne cause of death?
ds,	w requires that the death certifica been signed by the attanding ph should be detached for use as it									1 🗆 Y	9s 2 XN	o 3 Prob	ably 4 □Unknown
ecord	law rec as bee	ompleted								24a. Was a		4b. Were auto	psy findings available
ľ	ding Physician: The lav h. After this certificate has funeral director, page 2	mo								autops perform	ned? 2 X No	prior to condeath?	ກpletion of cause of
Vital	olan: ctor, i	BeC	25. Was case referred to medical examiner?					26. P	lace of Death	Check only on		12,103	2010
5	Physiclan: this certific ral director,	ဥ	1 ☐ Yes 2 🔀 No	Hospital: 1 Inpat		ER/Outpatien			Nursing Ho	me 5 🗆 Reside	ence 6 🗆	Other (Specify	v)
_	fing F After funera	ertification;	27. Manner of Death 1 SNatural 5 ☐ Pending		jury ay Year)	28b. Time of Injury		. Injury at Work?		28d. Describe ho	ow injury oc	curred	
DIVISION	r Attending F er death. rector: After by the funer	ficat	2 Accident investigation investigation Accident 6 Could not be a c	ot be 300 Place of Is	niury - At ho	me farm etr	M factors	1 Yes 2		28f. Location (Si	reet and N	umber or Pura	I Boute Number
2	affer affer Dire	ert	4  Homicide determin	building, e	tc. (Specify	<i>()</i>	sot, ractory,	omos		City or Town		arribor or 7 (arb	, riodio rambor,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	calC	29a. Certifier 1 Certifying	Physician: To the bes xaminer: On the basis	t of my kno	wledge, death	occurred at	the time, date	e and place,	and due to the c	ause(s) and	manner as s	ated.
	tha H hin 24 the F	Medical		and manner s	stated.	uori and/or in							
1	S tive S		29b. Signature and title of certifier	ME	DICAL	DOCTOR		License numb			9d. Date si	gned (Month,	Oay, Year)
	$\cap$		30. Name and address of person w					365-			IPRI	1 6)	XUUG
	0		PETER LEARY,	THE JOHN	s Hope	TINS L	5 PT+2	i Lox	5 NART	4 WAGES CH	east 6	Baitineson	Marylano 21705
-	Sta	_	31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	ture	ulle	- 100	- 14041	. 1400.0 21	-vect ,		- MELLEVIA E1502
£.	Registr	ar	0 DD 1 0	2006	a little all and	F A							

			For State Registrar	State of Maryla		partment of Fertificate of		Mental H	ygiene Reg. Nô.	6 11075
	Physici	an	1. Decedent's Name (First, Middle, La.			-11177	_	2. Date of Month	Death Day	3. Time of Death
	/Medic	al	do Facility Alama (16 and institution with	AUGUST EUG	ENE W		R .	APRI	4c. County	
	Examin	er	4a. Facility Name (If not institution, given GENESIS MULTI		NTER	TOWS				TIMORE
Lice .	Funeral		5. Social Security Number 6. S	ex 7. Age (In y	rs. last birthda	) If Under 1 Year		S. B. Date of I		Birthplace (State or Foreign Country)
и	Director		214-16-1666	<b>№</b> 2□F	83 Yrs.	Months Days	Hours Mir		1922	MARYLAND
	and w		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or	Location				10d. Inside City Limits
	Manyi f sho	tor	MD BALTIM	ORE	BALTI	MORE				1 ☐ Yes 2 No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?
	th with	alD	14 FRANCIS GRE	EN CIRCLE		212	21		USA	
36	72 hours after death with the Maryland natural', or Items 23s or 28s-f show deal Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent Ever is Armed Forces? 1 ☐ Yes 2 M No II Yes, Give Year or Dates:	1 U.S. 13	Was Decedent of H If Yes, specify Cub		Specify Yes or into Rican, etc.)		ce - American Indian, ck, White, etc.
21215-0036	in 72 hours n "natural", legical Exa	ted	15. Decedent's Ec	ducation	16a. Dec	edent's Usual Occup re kind of work done	pation	odvina	16b. Kind of B	usiness/Industry
218	를 . 출 를	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use retire	d)			
			9 17. Father's Name (First, Middle, Last)				TECHNIC		ELECTE	
ano	D to D	o Be		JES A. WEAV	ER			V. TA		ne)
Maryland	S D E E	ĭ	19a. Informant's Name/Relationship (			iling Address (Street	and Number or F	Rural Route Nur	nber, City or Town,	State, Zip Code)
	nd 2 lith a 27 is r tra		FAY LAY	- DAUGHTER	14 I	FRANCIS	GREEN C	CIRCLE	BALTI	MORE, MD 21221
ore,	ges 1 an t of Heal if item? or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Dameur from State	cemetery, cr	oosition (Name of ematory or other pla		Date		- City or Town, State
Ë.	Pag ment lant: I		74 □ Donation 5 □ Other (Specif	$S\Gamma$		'S CEMET				RUN, MD
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot once.		21. Signatura of Paneral Service Licer	nsee		22. Name and Address $54~{ m E}_{ullet}~{ m M}_{z}^{z}$				AL HOME , MD. 21157
			23a. Part1 Enter the disease, or com shock of heart failure. List only	plications that caused the done cause on each line.	eath. Do not e	nter the mode of dyi	ng, such as cardia	ac or respiratory	arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a. CUA						days
	/Medical Examiner		resulting in death)	Due to (or as a con.	sequence of):			_		
		- C	Sequentially list conditions,	b. Due to (or as a con:	sequence of):					monets
	uted ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	·	ENT	. A				cears
ó	an andrial-tra	Exa	resulting in death) Last	Due to (or as a con-						
8760	ate be executed thysician and the burial-transit	edicai		d						
9	leath certifica attending ph	/Med	IF FEMALE:	23c. If yes, outcome of pre	onanev	•			024 D	A. A. A. A. A. A. A. A. A. A. A. A. A. A
.O. Box	law requires that the death centificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	☐Ectopic pregnanc ☐ Other (specify) _	у			ite of delivery onth Day Year
Δ.	es that the de igned by the i be detached	by Ph	Part II. Other significant conditions of	ontributing to death but not	resulting in the	underlying cause gr	ven in Part I.	23e. Di	d tobacco use con	tribute to the cause of death?
rds	v requires been sign should be							1 (	]Yes 2□No	3 Probably 4 Hiknown
Records,	0 - 9	Completed							nformed?	Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
Vital	nystcian: Th nis certificate director, pag	BeC	25. Was case referred to medical examiner?				26. Place of De	eath (Check onl		
of V	S D	2	1 Yes 2 No	Hospital: 1 Inpatient 2			4X X un sing		sidence 6 Oth	
	Jing After fune	Certification:	27. Manner of Death  Natural 5 Pending  Natural investigatio	28a. Date of Injury (Month, Day Year	28b. Time Injury	Wo	rk? Yes 2 □ No	28d. Describ	e how injury occur	red
Division	tend leath tor: the	ficat	3 Suicide 6 Could not b	e 28e. Place of Injury - A	it home, larm,					ber or Rural Route Number,
D.	al or / s after il Dire	Serti	4  Homicide	building, etc. (Sp	ecify)			City or	Town, State)	
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical (		nysician: To the best of my miner: On the basis of exam and manner stated.						
	To the To the Comp	ž	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	d (Month, Day, Year)
)			Spepte M	D		D00	5315	<u></u>	APRIL	100, 500 6
			30. Name and address of person who Shawnina	completed cause of death (	1tem 23a) (Typ.	e. Print)  SANTI	AGO R	COHO	COL	110 21045 UMBIA
	Sta Registi		29b. Signature and title of certifier  Symple M  30. Name and address of person who  5 h A W N MA  31. Date liled (Month, Day, Year)  APR 1 0 2	32. Pogistrar's Si	gnature	Good				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend Item #10b,d,e&f &18 Per 9711 (285404) PROVIDE JH Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) APRIL 6, Day 2006 **Physician** 9:43 A M WINNER SHIRLEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE TOWSON HOSPICE OF BALTIMORE GILCHRIST CTR. tf Under 24 Hrs. 8. Date of Birth Month, Day 1924 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 🛱 F 81 MD 218-14-2790 Director Usuat Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h Count r then "natural", or itema 23a or 28a-f ehow the Medical Examiner must be notified at 1XX es -2 X No BALTIMORE N/A BALTIMORE Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number #308 USA 2416 HUNT DRIVE 6711 Park Heights Ave <del>21209</del> 21215 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: 2 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. Coltege (1-4or 5+) Elementary/Secondary (0-12) OWN HOME **HOMEMAKER** other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nd Mental YOFFA HORVITZ LILLIAN **Yaffe** MORRIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and A 19a. Informant's Name/Relationship (Type, Print) 3 SPRUCE COURT - OWINGS MILLS, MD 21117 t of Health a JODY GINSBERG / DAUGHTER Pages 1 and Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ä permit. Page Department o Important: if any injury or once. OHEB SHALOM MEMORIAL 04/07/2006 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (10 blastomA m) (atiams **Physician** montas /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien and as the burial-transit Due to (or as a consequence of): Division of Wital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death signed by the at id be detached for 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has t lirector, page 2 s autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOS PIC 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA မှ this 28a. Date of Injury (Month, Day Year) Director: After th 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; 1 Naturat 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or To the Funeral Directompletely filled in by 4 ☐ Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and into of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMON CHANGES, MM

6601 N. Charles St

29c. License number

D 58303

6,2006

BALTIMOR MD 2/204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

		4	For State Registrar	State of Maryland /	Department of H Certificate of L		ental Hygle Reg	6000	11077
	0		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		PHYLLIS WILL	AM S			APRIL	1 2006	
	Examin		4a. Facility Name (If not institution, give s			Location of Death		4c. County of Death	
			UNIVERSITY OF MAMICAN  5. Social Security Number  6. Sex	7. Age (In yrs. last b			8. Date of Birth	9. Birth	place (State or Foreign
l,	Funeral Director			M XXF 63	Yrs. Months Days	Hours Min.	(Month, Day, Y	42 Cou	MD
	land	-	10a. State 10b. County	10c. City, Tox	wn or Location				10d. Inside City Limits
	Maryl -f sho	to	MD Carrol	L	Westminste	r			1 ☐ Yes 2 XNo
	h the	irec	10e. Street and Number		10f. Zip Code		10g	. Citizen of What Cou	intry?
	th wit	a	3119 Salem Bott	om Road	211			U.S.A.	
99	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel; or items 23a or 28e-f show any injury or other treumatic event, it e Medical Examinar must be multified at once.	y Funeral Director	11. Marital Status  1 ☐ Never Married	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Spe in, Mexican, Puerto F Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	, etc.
21215-0036	turel;	ed by	15. Decedent's Edu	Year or Dates:	a. Decedent's Usual Occupa	ation	16	b. Kind of Business/l	Lack
5	in 72 n "ne M. d.c.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	Completed) College (1-4or 5+)	<ul> <li>Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired</li> </ul>	during most of workir l)			
212	d with giene er the	mo	12th grade	na A	ssembly Li	ne	[ ]	Western E	Electric
g	al Hy al Hy d othe vent,	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Name		iden Sumame)	
Maryland	Ment Ment arkec	10	Phillip Holly			Annie T			
Nar	2 sho and is m		19a. Informant's Name/Relationship (Type		b. Mailing Address (Street a				
	1 and Health em 27 ther 1		Lawrence Willia 20a. Method of Disposition	20b. Place	119 Salem of Disposition (Name of	D		C. Location - City or 1	
altimore,	Pages tment of t tent: If its jury or or		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Garri	ery, crematory or other placeson Forest	Vet. 4/	11/06	Owings Mi	ills, Md
Bai	Deparition Department Important Incomposition Incompositio		21. Signature of Puneral Service License	1 24 //	22. Name and Addres	H West	n 1. :	wa	21215
	40244		23a. Part 1. Enter the disease, or compli	cations that caused the death. Do	4300 Wab				21215 Approximate
	45		shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.					Interval Between Onset and Death
	Priysician /Medical		disease or condition resulting in death)	Due to (or as a consequence	ATTL DISSECT	700			ZA HEURS
	Examiner				o oi).				
	13/15	ner	if any, leading to immediate	Due to (or as a consequence	e of):				
de	ificate be executed g physician and as the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
68760,7	e exe	EX	resulting in death) Last	Due to (or as a consequence	e of):				
876	cate b	edical							
_	. □ O 6		IF FEMALE:	3c. If yes, outcome of pregnancy				23d. Date of deli	varv
.O. Box	w requires that the death certif been signed by the attending should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 氧 Unknown	1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	th 3 □Ectopic pregnancy 5 □ Other (specify)			Month	Day Year
<u>α</u>	The law requires that the ate has been signed by the bage 2 should be detached.	/ Ph	Part II. Other significant conditions con	atributing to death but not resulting	in the underlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
sp.	uires sign lld be	d by					1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Minknown
of Vital Records,	w req	Completed					24a. Was an	24b. Were au	topsy findings available
Re	The law cate has	шо		· · · · · · · · · · · · · · · · · · ·			autopsy performs 1 Yes 2		completion of cause of
ta		Ø.	25. Was case referred to medical			26. Place of Death			
f V	N N D	To B	examiner? 1 ☐ Yes 2 💢 No	lospital: 1 Inpatient 2 ER/0	Outpatient 3 DOA Oth	er: 4 Nursing Hor	ne 5 🗆 Residen	ce 6 □Other (Spec	city)
0 _	Attending Physicien: r death. ector: After this certific by the funeral director,		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury 28b (Month, Day Year)	Time of 28c. Injur	k?	28d. Describe how	injury occurred	
Sio	tendi leath. tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be		- des	Yes 2 □ No	19f Leasting (Stra	et and Number or Ru	eral Poute Number
Division	or At after d Direct in by	ertification;	4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	'	City or Town,	State)	rai Adale Namber,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	edical Ce		sician: To the best of my knowled ner: On the basis of examination					
	To the within 2 To the Complet	Med	29b. Signature and title of tifier	and manner stated.	29c. Licens	se number	290	d. Date signed (Monti	n, Day, Year)
	8 4 4 4		Min		N/A	4003		APAIL	1 2006
	$G_{i}$	8	// A	mpleted gause of death (Item 23a		75.4	5.5		
	10	1	Sina	C. Mornie R		22 5. 1	haeune s	SIM FOR BAL	riment, MI 21
	Sta Regist		31. Date filed (Month, Day, Year)	32 Registrar's Signature	Sperker				
7.	negist	aı	APR 1 0 200	O JUNEAU SO					

			For State Registrar	State of Maryla	-	artment of H		lental Hygie	4000	11079
Z):	Dhuni.ii	2	1. Decedent's Name (First, Middle, I	_ast)				2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic		Clarence Waters	;				March 21	, 2006	8:30 PM M
ı	Examin	ier	4a. Facility Name (If not institution, g				Location of Death		4c. County of Death	
- ,503		- *	Prince George 5. Social Security Numberunk 6		rs. last birthday)	Cheves	r Ly If Under 24 Hrs.	8. Date of Birth	Prince Ge	
	Funeral Director		5. Social Security Number CITE	1 M 2 □ F 5		Months Days	Hours Min.	(Month, Day, Ye	19/18 Wash	nplace (State or Foreign untry) nington DC
T	100		Usual Residence of Decedent					Julie 17,	1940 Wasi	IIIgton DC
200	E po		10a. State unk 10b. County	unk 10c.	City, Town or Lo	cation			unk	10d. Inside City Limits
2	- 4	cto								ınk <sub>1 □ Yes 2 □ No</sub>
ţ	or 2	Director	10e. Street and Number		un	k 10f. Zip Code		unk 10g.	Citizen of What Cou	untry?
t c	8 23e	rai		10.00			W . O O /O		USA	to a to do
an de	le le	Funeral	11, Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces?	n U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	14. Race - Amer Black, White	
D de ar	J. or	by	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🎇 No	Specify:		Specify: b1	ack
5 2	is all	ted	15. Decedent's (Specify only highest of			dent's Usual Occupa		166	o. Kind of Business/I	ndustry
1	. u	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	)	ing .		
<b>V</b> 5	ygier her th	Co	12	0	main	tenance e			entagon	
2 4	d off	Be	17. Father's Name (First, Middle, La	3()		unk	18. Mothers Name	e (First, Middle, Mai	den Su <i>mame)</i>	unk
<b>7</b>	Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "netural", or Items 23a or 28a-f ehow any injury or other treumatic event, I'm Medical Exam in Linual be inclined all once.	Ţ	19a. Informant's Name/Relationship	(Tuna Print)	10h Mailie	na Address (Stmat)	and Number or Pur	al Pouto Number C	ity or Town, State, Z	in Code)
בי ק ק	th an th an treu		Wiletta Macklin			-			ington, D	
ב ב	Heal tem 2		20a. Method of Disposition		b. Place of Dispo	sition (Name of	]		. Location - City or 1	
2	at: # 1		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ※ Other (Spe		сөтөтөгү, сгег	natory`or other plac	θ)			
	orter injur	1	21. Signature of Funeral Society Science Lice		22	. Name and Addres	s of Facility	CEE II D	altimore	Ctucat
	Deparement of the services once.	10	mount 1	. Wade livect	or St	altimore,	оту воага MD 2120		altimore	Street
78 \$1.5			23a. Part I. Enter the disease, or co shock, or heart failure. List on	implications that caused the d	leath. Do not ent		_			Approximate Interval Between
Р	hysician		Immediate Cause (Final disease or condition	FATAL C	ARDIAC	ARRH	YTHMIA			Onset and Death
	Medical xaminer		resulting in death)	Due to (or as a con.	sequence of):					
ì.	Adminer	<b>-</b>	Securitally list conditions, if any, leading to immediate	b. Due to /or or o	200110200 06)					
D	ısit	nlner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a con:	sequence or).					
ou, be executed	al-tra	Examin	that initiated events resulting in death) Last	c.  Due to (or as a con:	sequence of):					
oroc,	physician and the buriat-transit	dical		d						
≦ٍ وَ	d ph as th	Medi	IE ECHALC.							110
YOU SE	ed by the attending p detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1☐Live birth 2☐F		Ectopic pregnancy			23d. Date of delin	very Day Year
. d	the at	sici	1 Yes 2 No	4□Pregnant at time of 100 Unknown	of death 5	Other (specify)			Worth	Jay 19a1
, je	d by detacl		Part II. Other significant conditions	s contributing to death but not	resulting in the u	nderlying cause give	en in Part I	23e. Did tobac	co use contribute to	the cause of death?
, all	been signed I	d by	T GIVE CONTRACTOR	, some same and the	100011119 117 1110 1	ndonying oddoo give	311 41 1 4111.	1 ☐ Yes		,
Krediires	been	Completed						24a. Was an	24h Were aut	topsy findings available
ב ב	e has	g E						autopsy	prior to c death?	ompletion of cause of
ָבָּ ד <u>ַ</u>	ificate or. pa	ပိ	25. Was case referred to medical				26 Place of Death	1 ☐ Yes 2)X h (Check only one)	No 1 ☐ Yes	2 □ No
Veició	s cert direct	O B	examiner? 1 ☐ Yes 2 ☑ No	Hospitaf: 1 ☐ Inpatient 2	20 ER/Outpatier	nt 3 DOA Othe			e 6 Other (Spec	ufv)
5 5	ter thi	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time o		at	28d. Describe how i		
בּיל בּיל בּיל בּיל בּיל בּיל בּיל בּיל	or: At	atlc	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	ion	,,=.,		Yes 2□No			
	irecto	Certification:	3 Suicide 6 Could not 4 Homicide determine			eet, factory, office		28f. Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
בַּ ב	urs af erel D									
I	Fun Fun stely f	edical	29a. Certifier VX Certifying (Check only 2 Medical Ex	Physician: To the best of my aminer on the basis of examand manner stated.	knowledge, deat nination and/or in	h occurred at the time vestigation, in my of	ne, date and place, pinion, death occur	and due to the caus red at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
of the	within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and tiple of certifier	//		29c. License	number	29d.	Date signed (Month	n, Day, Year)
	> ~ 0		<b>)</b> (/X/	factor		13	18951		3/24/0	06
			30. Name and address of person wh			Print)	λ	1	-1-1-1-	20185
			DR GARY /LITTL			PITAL &	YK	CHEVA	EXLY MD	20/86
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Si	ignature				,	
	riegisti		APR 1 0	LUUG Propers	SP AND	3000				

				State of Maryland	d / Department of Health and N Certificate of Death		ene 006	1080
		Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
		/Medic	al.	Henry Joseph 2  4a_Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	3 2006 4c. County of Death	a:40Pm
		Funeral Director	er	5. Social Security Number 6. Sex 1X7 M 20 F 84	Rosedale	8. Date of Birth (Month, Day, Y July 22	'ear) Cou	place (State or Foreign ntry)
	]	DU 3		Usual Residence of Decedent	, Town or Location			10d. Inside City Limits
		Maryii I-f sho	tor	Maryland Baltimore		dalk		1 ☐ Yes 2 ☒ No
	1	or 288	Director	10e. Street and Number	10f. Zip Code		J. Citizen of What Cou	ntry?
		18 23a		3416 Loganview Drive  11. Marital Status 12. Was Decedent Ever in U.	21222		United Sta	
	5-0036	De lied within 72 nouts atter death with the maryland thygiene. A thygiene, or items 23a or 28a-f show event, I'm Medical Evaciliter mout be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced  Armed Forces?  Type s 2 No.  Widowed 4 Divorced  Year or Dates:	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White,	
1	15-0	nin 72 nours e. an "neturel", Medical Ere	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 16	b. Kind of Business/In	ndustry
2	2121	i z should be tried within n and Mental Hygiene. I is marked other than ' reumatic event, The Me	omo	Elementary/Secondary (0-12) College (1-4or 5+) 6 Years	Foreman		Manufact	uring
enr	pu	be liled will tal Hygien d other the	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ne (First, Middle, Ma		
7	Maryland	d 2 should th and Men 7 Is marke treumatic	2	Joseph Zorn  19a. Informant's Name/Relationship (Type, Print)(Daughter)	19h Mailing Address (Street and Number or Ru	Marie Cr		n Code)
	_	0 = 2 -		Mrs. JoAnne Baumgardner		sedale, M		21237
-	ω,			1 Burial 2XXCremation 3 Bemoval from State	ace of Disposition (Name of imetery, crematory or other place)		c. Location - City or To	
7	Itim	T = 1		'4 □Donation 5 □Other (Specify)  21. Signatur Funeral Service Licenses	Litop Service Corp. 4/7  22. Name and Address of Facility	/2006	Towson, M	Maryland
200	Ва	permit. Departm Importe any inju		Spayon Elem	Duda-Ruck Funeral 7922 Wise Ave. Du			nc. 222
10				23a. Part1. Enter the disease, or complications that caused the death shock, or hearffailure. List only one cause on each line.	. Do not enter the mode of dying, such as cardiac	or respiratory arrest	ryrand zr	Approximate Interval Between
		hysician /Medical		Immediate Cause (Hhal disease or condition resulting in death)  a	bral Haemarka	se.		Onset and Death
		Examiner		Due to (or as a consequ	ence of):			
	4/ 3	o ii	iner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):			
k		xecute and al-trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last   C. Due to (or as a consequ	ence of):			
	8760	cate be executed physicien and the burial-transit	dicai E	d				
	9 X 6	eath certific attending p	/Mec	IF FEMALE: 23c. If yes, outcome of pregnant			23d. Date of deliv	rerv
	D. Box	To the Hospital or Attending Prhysicien: The law requires that the death certificate be executed within £4 brours attendenth.  Or the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?  1   Yes   2   No   9   Unknown			Month	Day Year
	P.O.	res that the de igned by the be detached i		Part II. Other significent conditions contributing to death but not resu	Iting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to t	the cause of death?
	rds	w requires been sign should be	ed by			1 🗆 Yes	2 No 3 Pro	bably 4 Dinknown
	eco	e law re has bee je 2 sho	Completed			24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
	al B	certificate ha				performe	1 ☐ Yes	2□ No
	Vit	s certif	o Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 npatient 2	Other	th <i>(Check only one)</i> ome 5 ☐ Resident	ce 6 □Other (Specia	fv)
	Division of Vital Records,	ding Phys h. After this funeral di	on: T	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)	28b. Time of lnjury at Work?	28d. Describe how		,,
	isio	death. ctor: A y the fu	licati	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	28f. Location (Street	et and Number or Run	al Route Number,
	Ö	To the Hospitel or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	4 Homicide determined building, etc. (Specify	me, farm, street, factory, office )	City or Town,	State)	
		Hospi 24 hour Funer tely fill	Medical	29a. Certifier (Check only one)  1 Sertifying Physician: To the best of my know 2 Medicel Exeminer: On the basis of examinat and manner stated.	viedge, death occurred at the time, date and place ion and/or investigation, in my opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as s and place, and due t	stated. to the cause(s)
	l	ro the within 2 or the comple	Med	29b. Signature and title of opertifier	29c. License number	290	I. Date signed (Month,	Day, Year)
		- > - 0		Sehastian	JOL 00055171		04/03/	06
		141		30. Name and address of person who completed cause of death (Item 3023 Eastern Avenue	23a) (Type Print)	> >/>	Ш	
		Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signat	ure MI	) 2/20	L <b>7</b> )	
		Regist		APR 1 0 2005	freels.			
	DHM	IH 17 Rev 1/2	001	gradul 30	ORIGINAL			

			1 - For State Registrar		State of	Maryland	/ Depa		of He	ealth a		ental Hy	giene Reg. No.	006	11081
	Physic	ian	Decedent's Name (Fig. 1)	irst, Middle, L	ast)							2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi		JUNE		R.		AL	LEN				APRIL		2006	6:35 A. <sup>M</sup>
1	Examir	ner	4a. Facility Name (If not			ber)		4b. City, 1	own, or l	Location of	Death			county of Death	
			5. Social Security Number			Ago (la ura loca	ار رام طامتره ه	FO:		HILL If Under 24	4 Hrs	D. Data of Bio		RFORD	alass (State of Free in
	Funeral Director		220-07-797 Usual Residence of Dec	70	1□M 2 <b>K</b> ]F	'. Age (In yrs. las	Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da 6/26/	y, Year)	Cou	place (State or Foreign intry) RYLAND
	ehow			b. County		10c. City,	Town or Lo	cation						1	10d. Inside City Limits
	Many	to	MD	HARE	FORD	BEI	AIR								1 ☐ Yes 2 ☐ XNo
	h the	Director	10e. Street and Number	r				10f. Zip	Code				10g. Citize	en of What Cou	intry?
	th will	ai	1308 SCOI	TDALE	DRIVE U	NIT Q		2	1015	5			U	SA	
	- me	Funerai	11. Marital Status		12. Was Deced	lent Ever in U.S.	13.	Was Decede	ent of His	panic Origi Mexican	in? (Spe	cify Yes or No Rican, etc.)	- 14	4. Race - Amer Black, White	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or items 23s or 28s-1 show event, the Medical Examiner must be notified at	þ	1 Never Married  3 Widowed 4		1 □ Yes 2 If Yes, Give Year or Dat	2 □XNo	1	1 □ Yes 2		Specify:					HITE
5	72 h	Completed	15. (Specify o	Decedent's l	Education rade completed)		(Give	dent's Usual kind of worl	done du	tion uring most o	ol workii	ng	16b. Kind	d of Business/li	ndustry
12	within ene. then	mpi	Elementary/Secondar		College (1-	4or 5+)		DO NOT use MEMAKE	,				OTTAT	HOME	
2	filed with Hygiene other the		11TH GRAD 17. Father's Name (Firs				пОІ	MEMAKE		10 Mothod	a Noma	(First, Middle		HOME	
Maryland	ntal hed od od od od o	Be	JAMES KRE		1/								, Maiden 3	umame)	
Ë	and Men ie marke	은	19a. Informant's Name		(Tuna Print)		10h Mailie	Addross	Street or			HARRIS	as Cibras	Town State 7	a Cada)
Ma	d d d d d d d d d d d d d d d d d d d		NELSON D.											Town, State, Zi	
	t Healt tem 2 other		20a. Method of Disposit		OR./SON	20b. Plac	e of Dispo	TIFFA	e of			FOREST		ation - City or T	7050 own, State
ē	20= 5		1 Burial 2 □ Cr 4 □ Donation 5 □			tate	•	natory`or oti Nacina		1 .	. /10	12006			
Baltimore,	it orta		21. Signature of Funera			MORE		MEM.						ENDALE,	HOME, P.A.
ä	Peny one		10					521 L					WSON,		1286
			23a Part1. Enter the di	isease, or cor	mplications that car	used the death.									Approximate
>	Physician /Medical Examiner		Immediate Cause (Fina disease or condition resulting in death)		a. Pls Due to (o	pira to	or y nce of): I	Fa 1th y	ilv	re					Interval Between Onset and Death
68760,	te be executed ysician and te burial-transit	ical Examiner	Sequentially list condition of any, leading to immediate cause. Enter Underlyin Cause (Disease or injurthat initiated events resulting in death) Last	diate gy	c. Sev Due to (or	r as a consequent	nce of):	al'r	e ju	/r j1	tut	7 cn			
P.O. Box 68	that the death certificate bed by the attending physic detached for use as the b	Physician/Medi	IF FEMALE: 23b. Was decedent pre in the past 12 mon 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ths?		th 2 ☐ Fetal de nt at time of deat	ath 3	Ectopic pre					23	d. Date of deliver Month	rery Day Year
	Se G	2	Part II. Other significan	t conditions	contributing to dea	ith but not resulting	ng in the ur	nderlying ca	use giver	n in Part I.		23e. Did t			the cause of death?
300	aw requir ts been si 2 should	ompieted										24a. Was		24b. Were aut	opsy findings available
æ	o - 0	E									_	autor perfo	osy rmed? 2 2 No	prior to co death? 1 ☐ Yes	mpletion of cause of
ital	icien: Th certificate rector, pag	BeC	25. Was case referred to	o medical				-		26. Place o	of Death	(Check only o		1 103	2 140
<b>&gt;</b>	9 W =	2	examiner? 1 ☐ Yes 2 ☐ No		Hospital: 1 🗆 Ing	patient 2 ER	VOutpatien	t 3 DOA	Other	4 ☐ Nurs	ing Hon	ne 5□Resi	dence 50	ther speci	TILENCE
Division of Vital Records,	ding After fune		2 Accident	☐ Pending investigate	on	Injury 28 Day Year)	Bb. Time of Injury	M 28	c. Injury a Work?	at es 2 □ No		8d. Describe	now injury	occurred	
Divis	2 # # C	Certification:	3 Suicide 6	Could not i	1 28e. Place o	f Injury - At home g, etc. (Specify)	e, farm, str	et, factory,	office		2	18f. Location (: City or To		Number or Rur	al Route Number,
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1 (Check only 2 one)	Certifying P Medical Exa	hysician: To the b miner: On the bas and manne	is of examination	odge, death and/or inv	occurred a restigation, i	the time	, date and nion, death	place, a occurre	and due to the ed at the time,	cause(s) a date and p	nd manner as	stated. o the cause(s)
	To T with	Σ	29b. Signature and title	a_		_			License I	05	71	89	29d. Date	signed (Month)	Day, Year)
	5		30. Name an address of					•	A 12 5	D.D.	a	nn	15.0		
	Sta	to	LYNNE C. I			520 UPP.		LSAPE.	AKE .	DR.	SUIT	TE 201	BEL A	IR, MD	21014
Dr.	Sta Registr MH 17 Rev 1/2	ar	APR	1 200	- W	· A	Soon	K)			_				
JH	17 1100 1/2	JU 1			er.		ÖRIGII	VAL							

			For State Registrar	State	of Marylar		artment of H tificate of L		d Mental Hy	giene Reg. Ne. 00	6	11082
			1. Decedent's Name (First, Middle,	Last)					2. Date of De	ath	Year	3. Time of Death
	Physici /Medic		Cora Clark Aren	d					APRICE	322	ion	4 cop M
	Examin		4a. Facility Name (If not institution,	give street and n	umber)		4b. City, Town, or	Location of D	eath	4c. County	of Death	1
			Baltimore Washi	ngton Me	dical C	enter	Glen	menel	e c	ANK	RI	minder
	Funeral			S. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bir (Month, Da Sep. 27	th ly, Year)	9. Birthpl Coun	lace (State or Foreign try)
	Director		215-28-3432	1 □ M 2 🛣 F	75	Yrs.			Sep.27	, 1930	MD	
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. C	ty, Town or Lo	cation				1	Od. Inside City Limits
	sho	ក	,									1 ☐ Yes 2 🕱 No
	7-883-f	Director	MD Anne A	rundel		Severn	10f. Zip Code			10g. Citizen of V	Vhat Coun	
	with De C	百		1			,	,				uy:
	eath 23	erai	R 1065 Loving Ro		edent Ever in L	18 13 1	21144		2 (Specify Yes or No	U.S	• A • e - Americ	an Indian
15-0036	be filed within 72 hours after death with the Maryland lat Hygiene. d other then "natural", or Iteme 23a or 28a-f show event, it a Medical Examinating most be notified at	by Funerai	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed F	orces? 2 ⊠ No iive	1	fYes, specify Cuba I⊡Yes 2⊠ No	n, Mexican, P Specify:	? (Specify Yes or No luerto Rican, etc.)	Blac	k, White, o	etc.
ğ	2 hou		15. Decedent's				lent's Usual Occupa			16b. Kind of Bu	isiness/Inc	lustry
715	n 7	Completed	(Specify only highest Elementary/Secondary (0-12)	,	(1-4or 5+)	(Give life. L	kind of work done of DO NOT use retired	<i>furing</i> most of ()	working			
2	d with	E	Elementary/Secondary (0°12)	College	4	Lin	guist			Gover	nment	
פ	othe other	Be C	17. Father's Name (First, Middle, L.	ast)				18. Mother's	Name (First, Middle	, Maiden Sumam	10)	
<u>a</u>		ToE	Johnnie Clark					Lilli	ian Clark			
Maryland 21	s 1 and 2 should be filled v F Health and Mental Hygie Item 27 Is marked other i other treumatic event, II	•	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailin	g Address (Street a	and Number o	r Rural Route Numb	er, City or Town,	State, Zip	Code)
	and Salth		Anthony Clark A	rend / s				t., Apt	. 1; Wash			
Baltimore,	es 1 and 3 of Health filtem 27 r other tr		20a. Method of Disposition  1 DBurial 2 Cremation	Domeyal from		Place of Dispo cemetery, cren	sition (Name of natory or other plac	e)	Date	20c. Location -	City or To	wn, State
Ĕ	Pages nent of ent: If It ury or o		4 Donation 5 Other (Sp.			iendshi	p Cemeter	cy   4/	77/2006	Hanove	r, MD	
aĦ	permit. Pagi Depertment Importent: I eny Injury o		21. Signature vu jeral Servi	censee	***		. Name and Addres	s of Facility	Singleto	n Funera	al Ho	me, PA
m	88 E 8		tille		M014	11 1	Second A	Ave SW;	Glen Bur	nie,MD 2	21061	
			23a. Part . Enter the disease, or coshock, or 151 ailure. List o	omplications that	caused the dea	th. Do not ent	er the mode of dyin	g, such as car	rdiac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	P	JP400		Paval		-		1	Onset and Death
	/Medical		resulting in death)	aDue to	(or as a conse		n ac	0	.,,,		-	carras.
	Examiner		Conventially first and distance	h /	In se	Mal	anua					Hous. Hous Day!
	P =	ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or a conse	quence of):						20.0
9	cuted	Examiner	that initiated events	o	12/10	tensi	on				2	Hours
o Î	e exe ian a urial-	Ä	resulting in death) Last	Due to	o (of a conse	quence of):	/	-				D
8760,	cate be executed physician and the burial-transit	dicai		d	Mon	sucy	fogen	Les				DAYI
Ö	artific ing pl	Med	IF FEMALE:								1	
Box	leath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?		utcome of pregn birth 2 ☐ Fet	al death 3 □	Ectopic pregnancy			23d. Dat Mo	e of delive	ery Day Year
	e dea	sici	1 🗆 Yes 2 🗹 No 9 🗆 Unknown	4∏Preg 9□Unk	nant at time of	death 5	Other (specify)			1010		Day You
<u>о</u>	requires that the death certific seen signed by the attending p hould be detached for use as	Physician/Me	Part II. Other significant condition		d				22a Did		ribusa sa sh	ne cause of death?
ś	res tha signed be del	र्व	Part II. Other significant condition	s contributing to	death but not re	suiting in the ui	nderlying cause give	en in Part I.		Yes 2 ☐ No	3 ☐ Prob	
20	w require been sign	ted	- I recuire	, ,,,,,	14/11	100	cong c	222				
Division of Vital Records,	₹ 11 0	Completed							24a. Was	an 24b. V	Were autor	psy findings available inpletion of cause of
<u> </u>		S S								ormed? 2 No	death?	2₽No
Ħ	Attending Physician: or death. ector: After this certifics by the funeral director.	Be	25. Was case referred to medical examiner?						Death (Check only	one)		
<u>~</u>	hysic his ca Il dire	၉	1 ☐ Yes 2 € No	Hospital:	Inpatient 2	ER/Outpatien		4 🗆 1401311	ng Home 5 Res			Hospie
_	ng P Ifter t		27. Manner of Death  1 ■ Natural 5 ■ Pending	28a. Date (Mo	of Injury nth, Day Year)	28b. Time of Injury	28c. Injury Work	/ at k?	28d. Describe	how injury occurs	ed	
<u>s</u>	death. death. ctor: A y the fu	cati	2 Accident investiga 3 Suicide 6 Could no	ition			M 1 🗆	Yes 2 □No				
Ë	or Att	Certification;	4 Homicide determin	289. Plat	e of Injury · At I ding, etc. <i>(Spec</i>	nome, farm, str <i>ify)</i>	eet, factory, office		28f. Location ( City or To	Street and Numb wn, State)	er or Rura	I Route Number,
	urs a:											
	Hosp 24 hol Fune Fune	Medical	29a. Certifier 1 Certifying (Check only 2 Medical E	xaminer: On the	ne best of my kn basis of examin nner stated.	owledge, death ation and/or in	n occurred at the time vestigation, in my of	ne, date and p pinion, death (	place, and due to the occurred at the time,	date and place,	inner as st and due to	ated. the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Mec	29b. Signature and title of certifier	and ma	inioi statou.		29c. License	e number		29d. Date signe	d (Month,	Day, Year)
	F ≥ F 0		1 Inel	710				11-		do.	07	A9 7 -
	no		30. Name and address of person w	to completed and	use of death /Ita	m 23a) /Tuna	Print)	work	110 0h	11/Re	1 3	12 7006
	2		2 / // Y	han A	Para			eces i	ard De	0/1		
3	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Sign	ature	July 1	ne i	at on	Corr		
	Registi		ADD 1 1 2	006	Registrar's Sign	1 100	Sel.					
			HPR I I	UUU KARA	SEAN -	-						

Hospital or Attending Physician: Director: , hours after death 24 hours a

20kpl

Medical

30. Name and address of person who completed cause of death (Item 23a) 31. Date filed (Month, Day, Year) State

Homicide

29b. Signature and title of certifier

Zabiullah Ali, M.D. Assistant Medical Examiner 32. Resistrar's Signature

and manner stated.

determined

2006

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number OCME

29d. Date signed (Month, Day, Year)

April 8, 2006

Registrar

# Brock Mary L.

			1 - For State Registrar	State of Maryl	and / Dep		f Health and N	Mental Hyg		11001
	7%		Decedent's Name (First, Middle, La	st)				2. Date of Deat	h	3. Time of Death
	Physic /Medi		Mary Lee Brock					APRIL	8 2006	10.35A M
9	Exami		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Tow	m, or Location of Death	)	4c. County of Death	
de.			BACTIMORE WASHIM	IGTON MEDIC	AL CENT		EN BURI	412	ANNE 1	Francoel
	Funeral Director		213-20-3030	7. Age (In )	75 Yrs.	If Under 1 Ye Months Da	ear If Under 24 Hrs. ays Hours Min.	8. Date of Birth (Month, Day, Dec. 23	Year) 9. Birth Con 1930 Mar	place (State or Foreign intry) yland
	and		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
	the Maryl 28a-f eho	ector	Maryland Anne Ar	rundel Pa	asadena	104 7:- 000			On Ciair on of Mina Co	1 ☐ Yes 2 🔀 🐪 O
	with with the or	급	114 Club Road			10f. Zip Coo		1	0g. Citizen of What Cou U.S.A.	intry ?
	leath	era	11. Marital Status	12. Was Decedent Ever in	n U.S.   13.			pecify Yes or No-	14. Race - Amer	ican Indian.
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show sty injury or other traumatic event. It a Modical Examinar must be notified at SARS.	by Funeral Director	1 ☐ Never Married 2 ☐ Married  XX Widowed 4 ☐ Divorced	Armed Forces? 1 □Yes → □ No If Yes, Give Year or Dates:		If Yes, specify (	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	o Rican, etc.)	Black, White	
21215-0036	hin 72 ho s. on "natur Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual Oc kind of work do DO NOT use re	ecupation one during most of work stired)	king	16b. Kind of Business/I	ndustry
21	buld be filed with Mental Hygiene. Brked other thei atic event, the	COU	8		Homen	naker			Own Home	
nd	tal Hy d oth	Be	17. Father's Name (First, Middle, Last	)			18. Mother's Nam	ne (First, Middle, A	Maiden Surname)	
yla	should and Men marke umatic	2	William Heller					Worston		
Maryland	12 sho h and 7 le mu traum		19a. Informant's Name/Relationship (						City or Town, State, Z	p Code)
	1 and Health em 27 ther tr		Martin Brock (Son		b. Place of Dispo cemetery, cre				land 21122 20c. Location - City or 1	own. State
Baltimore,	permit. Pages Department of I Important: If it eny injury or o		D☐Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	(y) G	ardens C	of Faith	<sub>l</sub> April		Baltimore	
Bal	Departr Departr Imports eny inju	<	21. Signature of Funeral Service Lice	9696	1	2. Name and Ac	ddress of Facility Bruzdzinsk 1 Eastern A	i Funera venue, E	l Home, P. <i>l</i> ssex, Mary	A Land 21221
	Physician		23a. Pan Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the done cause on each line.					est,	Approximate Interval Between Onset and Death
	/Medical Examiner	L		b. CHRONIC  Dup to (or as a con:	sequence of):	METIVE	= Pulmos	IARY	DISEASE	
	s be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	c. The PHE  Due to (or as a con:	sequence of):	VA8CU	LAR E	SASAS TE	臣	
68760,	cate be ex physician the buria	Ca		d	3040030 3.7.					
.O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and oase 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pegnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	⊒Ectopic pregna ⊒ Other (specify			23d. Date of delin	very Day Year
Records, P.	quires that n signed b	þ	Part II. Other significant conditions of	contributing to death but not	resulting in the u	inderlying cause	given in Part I.		pacco use contribute to	
Ö	w requires sis peen si	Completed						24a. Was ar	n 24b. Were aut	opsy findings available
Re	The law te has age 2	шо						autops perform		ompletion of cause of
Vital		0	25. Was case referred to medical		-		26. Place of Dea	th (Check only one		2010
Į √	Physicien: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	P ☐ ER/Outpatier	nt 3 DOA	Other: 4 Nursing H	ome 5 Reside	nce 6 □Other (Spec	ify)
	te the		27. Manny of Death 1	28a. Date of Injury (Month, Day Year	28b. Time o Injury	'	Injury at Work? 1 □ Yes 2 □ No	28d. Describe ho	w injury occurred	
Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral	Certification;	3 Suicide 6 Could not b 4 Homicide determined		t home, farm, str ecify)	reet, factory, off	ice	28f. Location (Str City or Town	reet and Number or Ru , State)	ral Route Number,
	Hospi 4 hour Tunar ely fill	edicai	(Check only 2   Medical Exar	nysician: To the best of my miner: On the basis of exam	knowledge, deat	h occurred at th	ne time, date and place,	, and due to the ca	ause(s) and manner as	stated.
	the hin 24th F	Med	one)	and manner stated.						
	5 ½ 5 g		29b. Signature and title of certifier	77	ns	729C. LIG	cense number		HRAL &	
	3 1		30. Name and addless of person who	- 142 -	tem 23a) (Type,	Print)	Glen B	wrie	mo :	2061
	St Regist	ate	31. Date filed (Month Da), Year)	Registrar's Si	gnature	de				

DHMH 17 Rev 1/2001

Boughan, Myra

M300454621

ORIGINAL

				State of Maryland / D	epartment	of Health and M	lental Hygic	ene	
		•	1 - State Registrar	-	•	of Death		12006	11086
	Physicia	an l	1. Decedent's Name (First, Middle, Last)				Date of Death     Month	Day Year	3. Time of Death
	/Medic	al	CHRISTIANA  4a. Facility Name (If not institution, give st	BENUET		Town, or Location of Death	MPRIL	4c. County of Deat	
	Examin	er	JOHNS HOPKINS BAY			2	RE		
	Funeral		5 Social Security Number 6. Sex	7. Age (In yrs. last birti	hday) If Under	1 Year   If Under 24 Hrs. Days   Hours   Min.	8. Date of Birth (Month, Day,	(ear) 9. Birt	hplace (State or Foreign untry)
	Director	}	Usuel Residence of Decedent	4201	rs.		2-14-10	180 M	aryland
	yland yow		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
	e Mar	ctor	mo Hart	ord 15a	Iduol	<u>n</u>			1 ☐ Yes 2 ☑ No
	with th	Director	10e. Street and Number	stallana	10f. Zip	Code 7 1 1 1 2	10	g. Citizen of What Co	untry?
	heath me 23	Funeral	11. Marital Status	2. Was Decedent Ever in U.S.	13. Was Deced	ent of Hispanic Origin? (Sp ify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
٥	or Ital		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ( No If Yes, Give	1 Yes, spec		rican, etc.)	Black, Whit	)hite
2-0036	be filed within 72 hours after death with the Maryland ital Hyglene.  id other than "natural", or Itame 23a or 28a-f ehow event, the Maxical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Educ	Year or Dates:	Decedent's Usua	LOccupation	110	6b. Kind of Business	Industry
<u>۲</u>	n "nal	plete	(Specify only highest grade Elementary/Secondary (0-12)		(Give kind of work life. DO NOT us	k done during most of work	ing	,	, i
717	er the	Completed		NA	Ser	ver		Lagles 1	west.
and	be d la be	Be	17. Father's Name (First, Middle, Last)	+ Civio		18. Mother's Nam	e (First, Middle, Mi	aiden Sumame)  Mo Ko	VOCKI
Maryla	2 should be and Menta le marked sumatic ex	ဥ	19a. Informant's Name/Relationship (Typ	e, Print) 19b.	Mailing Address	(Street and Number or Rui	al Route Number,	City or Town, State,	Zip Code)
	12 E Z		linda A Ro	th (mother) 2	708 C	rustal La	ne Ba	Idwin n	2021013
Baltimore,	0 0 = =		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	cemeter	Disposition (Name y, crematory or at		Date 2	oc. Location - City or	Town, State
Ĕ	permit. Pages Department of Importent: If It eny Injury or o		4 Donation 5 Other (Specify)	churc	h Cem	e fenulation of Address of Eacility	0/00)	ringsv	ille, mo
ga	Departing Department of the Popular It It It It It It It It It It It It It		21. Signature of Fune at Service Cicenss		crema	reticer	of Athern 2325 York	ra Timo	nion, MD 21693
			23a. Part1. Enter the disease, or comp is shock, or heart failure. List only or	ations that caused the death. Do r					Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	ANOXIA	BRAIN	INJURY			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of	of):				
	4	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	of):	NFARCTION			-
Q	and I-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events						
60,	ite be executed lysician and ne burial-transit		resulting in death) Last	Due to (or as a consequence of	of):				
6876	e ys	dicai	d.						
	n certifi Inding use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	Bc. If yes, outcome of pregnancy	2 🗆 🗆 🗆			23d. Date of de	•
P.O. Box	w requires that the death certifica been signed by the attending ph should be detached for use as th	Physician/Med	in the past 12 months? 1 ☐ yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □Ectopic pro 5 □ Other (sp			Month	Day Year
<u>Р</u>	hat the d by ti	Phy	9 YUnknown  Part II. Other significant conditions con		the underlying c	ause given in Part I.	23e. Did toba	acco use contribute to	o the cause of death?
ds,	uires t signe Id be c	d by	, at the original contains to the	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			1 ☐ Yes	s 2□No 3□P	robably 4 Unknown
Division of Vital Records,	s beer s shou	Completed					24a. Was an	24b. Were a	utopsy findings available completion of cause of
Be	The la	mo.					autopsy perform 1 Yes 2	ed death?	
ita	cian: ertifica ector.	Be	25. Was case referred to medical examiner?	ospital:		Other	th Check only one		
5	Physi r this o	2	1 M Yes 2 No ☐	1 Ke Inpatient 2 ENVO		OA 4 Nursing H	ome 5 Resider	nce 6 Other (Spe winjury occurred	ecify)
on	nding ath. r: Afte e fune	atlor	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	njury M	Work? 1 ☐ Yes 2 ☐ No			
Vis	I or Atte after des Directo	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)	ırm, street, factory	, office	28f. Location (Str. City or Town,	eet and Number or R State)	ural Route Number,
٥	pital o		20a Cartifier 158 Cartifying Phys	isians To the heat of my knowledge	a death occurred	at the time, date and place	and due to the ca	use(s) and manner a	e etated
	To the Hospital or Atlanding Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atlanding phy completely filled in by the funeral director, page 2 should be detached for use as it	Medical		cician: To the best of my knowledge ter: On the basis of examination an and manner stated.					
	within To the compl	Me	29b. Signature and title of certifier	. ~	290	c. License number	29	d. Date signed (Mon	th. Day, Year)
			1 m	MI		ESUDO		4/10/0	,6.
	1		30. Name and address of person who co	mpleted cause of death (Item 23a)  200 E  32 Registrar's Signature	(Type, Print)	AUP Br	Homore	mn 2	1224
le:	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Coarle	JVC · LL	1111010	11110	
	Regist		APR 1 1 20	06 Brewer St.	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U 🖯 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month **Physician** URROUGHS 12:12 AM 2006 UELINE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1SALTIMORE TIMORE BERNADOTTE 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)

ERMANY 6. Sex 5. Social Security Number **Funeral** Days Hours Months 217-66 8144 1 M 2 F Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show the Mudical Examiner must be notified at 1 Yes 2 No GALTIMORE Director SALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21234 USA BERNADOTTE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or iteme 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "naturel" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7. In and Mental Hygiene. 7 Is marked other then "n. Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATOR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1-1IT MARGARET NA NHD( 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 le BURROUGHS 1120 OLD 10 FACESTON FALLSTEN KICK 21047 SPUJSE mo 20b. Place of Disposition (Name of cometery, crematory or other place)

DILANE ACCEPTION OF THE CONTROL OF THE 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ment of H ant: if ite ury or ot APRIL 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: if eny injury or 4 ☐ Donation 5 ☐ Other (Specify) 13,2006 IIMONIUM. MO YOU HARFORD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee FUNERAL CHAPEC PARKVILLE MD 21234 EUANS 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Drath tostur Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ed by the ettending physicien and detached for use as the burlal-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. ģ After this certificate has been signe funeral director, page 2 should be a 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 > 0 24a. Was an 1 Yes To the Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death Check onli one Be examiner? Other: 4 Nursing Home 1 ☐ Yes 2 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Descrive how injury occurred Certification: 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident 3 ☐ Suicide investigation Director 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Direct completely filled in by t 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manger stated. one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certified

Registrar
DHMH 17 Rev 1/2001

0

State

and address of person

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last 10 pm Month Year **Physician** 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death umber Facility Name (If not institution, give street-and **Examiner** 90 Tallon. ur If Under 24 Hrs. 7. Age (In vrs. last birthday) If Under 1 Year Social Security Number 6. Sex **Funeral** Days Hours -30-160 1 ☑ M 2 □ F Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10b. County City, Town or Location 10a State rai', or itams 23e or 28a-f show Examiner roust be notified at 1 Yes 2 □ No Director more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Pages 1 and 2 should be filed within 72 hours after death Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Amled Folces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No Specify: Specify: 3 Widowed 4 □ Divorced þ "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry traumatic evant, I've Madical TIMOr Elementary/Secondary (0-12) othar then College (1-4or 5+) Hygiene. th grade 99 Name (First, Middle, Maiden Si Father's Name (First, Middle, Last) Be and Mental I umbus and Number or Rural City or Town, State, Lip Code) 21207 19b. Mailing Address (Str. 19a. Informant's Name/Relationship (Type, Print) rtant: If itam 27 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facilit Dep-Impo any ir 23a. Part | Enter the disease of complications that caus of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on early line. Approximate Interval Between Onset and Death Immediate Cause (Final ZHEIM Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of: Examiner Hospitel or Attanding Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, the attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed Division of Vital Records, þ pe 4 Unknown 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has director, page 2 20 No 1 Yes 2. No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 6 ☐ Other (Specify) 3□ DOA Nursing Home 5 Residence 1 🗌 Yes 2 No Certification: To his funeral 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manper of Death 28a. Date of Injury After (Month, Day Year) 1 Natural 5 Pending investigation 2 No death. 1 TYes 2 Accident after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31

DHMH 17 Rev 1/2001

220

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

2006

D28595

			For State Registrar	State of Maryland / [		rtment of H			giene	06 11089	
ı	Physicia	an	Decedent's Name (First, Middle, Last)	2	11			2. Date of Dea Month	ith Day	Year 4:2/A	м
	/Medic Examin	al	4a. Facility Name (If not institution, give s	treet and number)	11	4b. City, Town, or		Death		ty of Death	
			Renaissance C		45 45 4	Catons		A Hrs. Lo. Day of Bid		1timore	
	Funeral Director		5. Social Security Number 6. Sex 1	NA CONTRACTOR OF THE PARTY OF T	Yrs.	Months Days	Hours	Min. 8. Date of Birt (Month, Date)	1920	9. Birthplace (State or Foreig Country) Massachusetts	<i></i>
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	n or Loc	ation				10d. Inside City Limit	s
	e Mary Ra-f sh	ctor	MD Bal	timore			nsvil			1 □ Yes 2 N	0
	with th	Funeral Director	1Qe. Street and Number	_		10f. Zip Code	0100		10g. Citizen of	f What Country?	
	ns 23	eral	709 Maiden Choice	2. Was Decedent Ever in U.S.	13. W	/as Decedent of Hi	2122 spanic Orig	in? (Specify Yes or No		USA ace - American Indian,	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturet", or Items 23a or 28a-f show important: If item 27 is marked other than "naturet", or Items 23a or 28a-f show althy injury or other treumatic event. It is M. died Ex. minst in util be notified at ODGs.	by Fun	1 ☐ Never Married 2 ☐ Married 3 🏋 Widowed 4 ☐ Divorced	Armed Forces? 1		Yes, specify Cuba	n, Mexican, Specify:	Puerto Rican, etc.)	Speci	ack, White, etc.  ify:  White	
5-0036	2 hour	ted t	15. Decedent's Educ (Specify only highest grade	cation 16a	. Deced	ent's Usual Occupa	ation	of working	16b. Kind of I	Business/Industry	
21218	ne. han "r	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired	)	or working	Or	vn Home	
Q 25	filed v Hygie other t	e Co	17. Father's Name (First, Middle, Last)	4	HO	memaker	18. Mother	r's Name (First, Middle,			
Maryland	should be nd Mental marked o	To Be	Mark	Hudson				ern	Litt		-
Mar	d 2 sho h and 7 Is mu treum		19a. Informant's Name/Relationship (Type	1.		•		r or Rural Route Number	-		(1)
	s 1 and f Health item 27 other to		Marcia R. Bell, da 20a. Method of Disposition	20b. Place o		sition (Name of patory or other place		Date Date		- City or Town, State	
altimore,	Pages ment of ant: If it ury or o		1 ☐ Burial 2 X Cremation 3 ☐ R.  '4 ☐ Donation 5 ☐ Other (Specify)	Metro	o Cr	ematory,	Inc.	04/11/06	Ba1t	timore, MD	
Balt	permit. Departi Importi eny inj		21. Signature of Funeral Service License	George MacNabb	22.	Name and Addres		Cremation		ty of MD, Inc.	3
	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do le cause on each line.  Due to (or as a consequence		er the mode of dying	g, such as	cardiac or respiratory a	rest,	Approximate Interval Between Onset and Death	
	Examiner	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause joils also in injury	Due to (or as a consequence	of):						
8760,	cate be executed physician and the burial-transit	edical Examine	that initiated events resulting in death) Last	Due to (or as a consequence	of):						
O. Box 6	ath certifi attending for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)				Date of delivery Month Day Year	Ŋ
ds, P.O.	es that gned b	by	Part II. Other significant conditions con End-Stage Der		in the ur	nderlying cause give	en in Part I.		obacco use co	ntribute to the cause of death?	wn
Vital Records,	w require been si should l	ompleted	Siv singe ise	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				24a. Was	an 24b	o. Were autopsy findings availab	ole
l Re	The larate has	Comp						autor perfo	med? 2 No	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	1
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		Oth		of Death (Check only o			-
of	Phys rthis ral dii	ıtlon; To	1 Yes 2 No  27. Manney Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b.	Time of Injury	28c. Injun Worl	y at	rsing Home 5 Resi			
Division	l or Atter after dea Director	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	farm, str	eet, factory, office		28f. Location ( City or To		mber or Rural Route Number,	
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: Afte completely filled in by the fune	edical C	29a. Certifier (Check only one)	sician: To the best of my knowledg ner: On the basis of examination a and manner stated.	ge, death ind/or inv	occurred at the tin vestigation, in my o	ne, date an pinion, dea	d place, and due to the th occurred at the time,	cause(s) and r date and place	manner as stated. e, and due to the cause(s)	
	To the within 2 To the complet	Med	29b. Signature and title of certifier			29c. Licens	e number		29d. Date sign	ned (Month, Day, Year)	
			Denen B	enli, ms		DYY.	37-3	<del>-</del>	4/8	9/06	
	3		30. Name and address of person who co	empleted cause of death (Item 23a)	) (Type,	Print)	10.	Comme	110	10.10 212 9 0	
	St	ate	31. Date filed (Month, Day, Year)	32. Degistrar's Signature	en (	ou) ce	Lun	, wirns	11111	ma) 2/228	
	Regist		APR 1 1 20	106 Benever St.	A	and I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Vear **Physician** bennin 715 AM 06 George /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Baltimore Oak Crest Village Parkville If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1**∑**M 2□F Yrs. 84 19, 1920 Maryland Director 215-12-7934 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location with the Maryland 10a. State 10b County or 28a-1 show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Parkville 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21234 items 23a 8620 Walther Blvd within 72 hours after death Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 1 □ Never Married 2 □ Married 0 1 ☐ Yes 2√ No Specify: If Yes, Give Year or Dates: Specify: 3 ♥ Widowed 4 □ Divorced þ White "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than Hygiene. Mechanic 12th. Grade Aerospace 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) 36 Pages 1 and 2 should be nent of Health and Mental is markad Freda Schmaiz1 George Benjamin Benner, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) itam 27 Harriet H. Bruns/Sister 12 B Brook Farm Ct Perry Hall MD 21128 Itimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. 4/11/2006 Greenwood Cemetery Orlando -22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. 21. Signature of Funeral Service Licensee 6415 Belair Road Baltimore MD 21206 m cilications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Joisease of Injury Due to (or as a consequence of): Examiner certificate be executed use as the burial-transit Cause (Disease or inju-that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. nding physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy the atter Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Records. The law requires page 2 should be 1 Yes 2 No 3 Probably 4 Unknown worthallator Completed 24b. Were autopsy findings available prior to completion of cause of death? dementa 24a. Was an certificate has autopsy performed 1 ☐ Yes 2 ☐ No 2 🗆 No Vital Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No 2 After this 28a. Date of Injury (Month, Day Year) 780R 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Diractor: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely within 2 29c. Litense number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 24246 06

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Yea

Wather Blod Parkerle ind 21234

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Bluce Bunutum 48800 W

1 2006

Year)

32. Restrar's Signature

DHMH 17 Rev 1/2001

2006

		1	For State Registrar	State of Maryland / Depa <i>Cer</i>	rtment of Health an tificate of Death		giene 006	11092
ı	Physicia	_	1. Decedent's Name (First, Middle, Last)  GERARD	B	ONIE	2. Date of De Month A PRIL	Day Year	3. Time of Death
)	/Medic Examin	er '	a. Facility Name (If not institution, give st	reet and number)	4b. City, Town, or Location of (	Death	4c. County of Dea	h
	Funeral		JOHNS HOPKINS BAYV  5. Social Security Number  6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Months Days Hours		th 9 Birt	hplace (State or Foreign
	Director		214.04.4163 Usual Residence of Decedent	M 2□ F 34 Yrs.	55,5	10.02.	1971	MD
	ehow		10a. State 10b. County  MD NA	10c. City, Town or Lo BALTIMOR	-			10d. Inside City Limits 1   Yes 2   No
	or 28a-1	Director	10e, Street and Number		10f. Zip Code		10g. Citizen of What Co	puntry?
	leath w	Funerai I	911 CHAUNCEY AVE		21217 Vas Decedent of Hispanic Origin Yes, specify Cuban, Mexican, F	? (Specify Yes or No	usa 14. Race - Ame	
36	be filed within 72 hours after death with the Maryland all Hygiene. All Hygiene did the then "ratural", or items 23a or 28a-f ehow order, the Madical Examinar most be notified at event, the Madical Examinar most be notified at	by Fun	1 ⊠ Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 2 MR No	r Yes, specify Cuban, Mexican, i I□Yes 2 <b>⊠</b> ,No <i>Specify:</i>	Puerto Rican, etc.)	C	e, etc. ACK
2-0	72 hou nature	eted	15. Decedent's Educ (Specify only highest grade	ation 16a. Decer	lent's Usual Occupation kind of work done during most of DO NOT use retired)	f working	16b. Kind of Business	
21215-0036		Completed	Elementary/Secondary (0-12)	College (1-4or 5+) NA SECUA	ITN GUARD			ALTIMORE
and	uld be filed Mental Hygi irked other itic event, i	Be	17. Father's Name (First, Middle, Last) GENERAL W. BOWE	SR.		Name (First, Middle A BESSIC		
Maryland	2 sho and h	2	19a. Informant's Name/Relationship (Typ	e, Print) 19b. Mailir	ng Address (Street and Number	or Rural Route Numb	er, City or Town, State,	Zip Code)
45	s 1 and of Heelth Item 27 other tr		GAYNELL HARRIS 20a. Method of Disposition	20b. Place of Dispo		Date Date	20c. Location - City or	Town, State
Baltimore,	permit. Peges 1 Department of H Important: If Ite any Injury or ott		1 Burial 2 Excremation 3 Re 4 Donation 5 Other (Specify)	GREENMO	unt of	. 08.06	BAUTMORE	, MD
Bal	Departing any in		21. Signature of Funeral Service License	51	Name and Address of Facility UGHN C. GREEN  51 BAUD. NATU	PIKE, BAL	10. MO 212	29
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	a cause on each line.		ardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
ł	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequence of):	INJURY			
		Jer	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	OVERDOSE	1 09		
/	xecuted end al-transit	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):		White die	, Y	
8760,	ate be executed thysicien end the burial-transit	dical E	٥		7	ONED BY MI		
Box 6	death certificate be executed e ettending physicien end od for use as the burial-transii	Physician/Med	23b. was decedent pregnant	ic. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 3 [	⊒Ectopic regnany cities	10	23d. Date of do	elivery Day Year
o.	it the dea by the et tached fo	hysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of death 5 □ 9 Unknown	Other (speed)	-		
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditions con	tributing to death but not resulting in the u	nderlying cause given in Part I.		tobacco use contribute Yes 2⊠No 3□F	to the cause of death? Probably 4 ☐Unknown
of Vital Record	The far te has age 2	Completed				24a. Wa auto peri 1 🗆 Yes	s an 24b. Were a prior to death?	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other	of Death (Check only	one) sidence 6 □Other (Sp	ecify)
	ng Phy Mer this Ineral d	on: To	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury at Work?	28d. Describe	how injury occurred	1
Division	To the Hospital or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	M 1 ☐ Yes 2 AN reet, factory, office	28f. Location	(Street and Number or I	Rural Route Number,
۵	Hospital or A 24 hours after Funerel Directely filled in by			ician: To the best of my knowledge, dea	th occurred at the time, date and	911 9	houseyl	as stated.
	the Hos in 24 hc the Fun	ledical	(Check only 2 Medical Examination)	ner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death	n occurred at the time	e, date and place, and di	ae to the cause(s)
	To the within 2 To the complete	Σ	29b. Signature and title of certifier  \[ \cdot	lado, M·D	RES OO!		APRIL: 2	
	1		30. Name and address of person who concludes the FALAS AVEN UE, BALTIS	mpleted cause of death (Item 23a) (Type DE , JOHNS HOPKINS WORE, MD 21128	Print) BAYVIEW MED	ICAL CEN	TER , 4940	EASTERN
	St	ate	31. Date filed (Month, Day, Year)  APR 1 1 208	32. Registrar's Signature	att 1			

			State of Maryland / Department of Health and Me  1- State Registrar Registrar Amend Items 24a,25,26,27 per 147 5856,0/6411,/06dhl	ntal Hygie <b>b</b>	Pne 0 0 6	1093
		Š.	1. Decedent's Name (First, Middle, Last)	. Date of Death		3. Time of Death
	Physici	-	Huey Lee Burch	Month 3	Day Year	12:25 A M
	/Medic Examin	1	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Death	
			Prince George's Hospital Conter Cheverly		Prince Geo	Α
	<ul><li>Funeral Director</li></ul>		436-62-9480 15 M 2 F 61 Yrs. Months Days Hours Min.	Date of Birth (Month, Day, Y	ear) Cou	place (State or Foreign ntry) siana
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	1		10d. Inside City Limits
	f sho	ō	MD Prince George's Capitol Heights			1 ☐ Yes 2½ No
	the 1	Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Cou	ntry?
	h with	ai D	1104 Booth Lane 20743		USA	
21215-0036	I within 72 hours after death with the Maryland liene. I then "neturel", or Items 23a or 28a-f show The Medical Examinar must be redified at	by Funerai I	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes, Give 1  1 Yes 2 No If Yes, Give 1  1 Yes 2 No If Yes, Give 1  1 Yes 2 No If Yes, Give 1  1 Yes 2 No If Yes, Give 1  1 Yes 2 No Specify:	fy Yes or No- can, etc.)	14. Race - Ameri Black, White Specify: bla	etc.
Ö	2 hou			16	b. Kind of Business/Ir	ndustry
218	within 7 ene. than "r	Completed	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12)  College (1-4or 5+)		. 11	
2	filed with Hygiene. Ather thai	Con	11 0 bricklayer		mmerical b	unk
nd	e d a b ≥	Be	17. Father's Name (First, Middle, Last)  Carl Burch	First, Middle, Ma	iden Sumame)	dirk
Maryland	Mer Mer	욘		Pauta Alumbas C	Site of Tour State 7	n Codol
Mai			19a. Informant's Name/Relationship ( <i>Type</i> , <i>Print</i> )  19b. Mailing Address ( <i>Street and Number or Rural F</i> Chester Allen Sr/brother  5 Roberts Street Staffo			<i>D</i> C004 <i>)</i>
	is 1 and 2 if Health a item 27 is other trai	- 8	20a Method of Disposition 20b. Place of Disposition (Name of Dat		c. Location - City or T	own, State
nor			1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) in State			
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Euneral Service Licensee Ronald S. Wade, Director State Anatomy Board	655 W. E	Baltimore :	Street
45	- 6		Baltimore, MD 21201  23a. Pany. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or or	respiratory arrest		Approximate
34			shock, or heart failure. List only one cause on each line. Anoxic			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  a. Hepatic Encephal o postry			
	Examiner		Scots - aborth			
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):			
	d d ansit	Examin	cause. Enter Underrying Cause (Disease or injury that initiated events  c			
ó	sician and burial-transit					
8760	ate be	icai	d			
9	n certifica anding ph use as ti	Med	IF FEMALE:			
.O. Box	death e atte	Physician/Medical	23b. Was decedent pregnant In the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)	=	23d. Date of deliv Month	reny Day Year
۵.	s that ned b e deta	by Pt		23e. Did toba	cco use contribute to	the cause of death?
rds	w requires been sign should be			1 🗆 Yes	2 □ No 3 □ Pro	bably 4 □Unknown
of Vital Records,	The tar	Completed		24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of
/ita	e iji	Be (	25. Was case referred to medical 26. Place of Death (	Check only one		
=	Physicia this cert	ပ္			ce 6 ☐Other (Spec	fy)
	ding P h. After funera	on:	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28c. Injury at Work?	d. Describe how	injury occurred	
Sic	ten feat for: the	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28	f Location (Stre	et and Number or Rui	al Route Number
Division	after d after d Direct d in by	Certification;	4 Homicide determined building, etc. (Specify)	City or Town,		ar rodio ridinosi,
	Hospita 4 hours Funera ely fille	edical C		d due to the cau at the time, date	se(s) and manner as a and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier 29c. License number	290	I. Date signed (Month	Day, Year)
	r s r o		Karen R Brooks MD DO04218	3	3/21/0	( a
•			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	, _	of ail o	9
			Prince George's Hospital Center			
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
1	Regist	ar	APR 1 1 2006 Market 15			

24E-3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#19b, perFH 0854 4 14/06 TT State of Maryland / Department of Health and Mental Hygiene Reg. No. 1 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death Day 1. Decedent's Name (First, Middle, Last) Month RIL 2006 11:10AM **Physician** Cate Brown Dorothy /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
Saint Joseph Medical Center 4b. City, Town, or Location of Death Examiner Towson Baltimore 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1□M 2X)F Pennsylvania 212-22-2653 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location 28a-f show f Heelth and Mental Hygiene. Item 27 is marked other then "natural", or Iteme 23a or 28a-1 shov other traumatic event, the Medical Example minust be notified at 1 Yes 2 No Parkville Directo Maryland Baltimore 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 21234 U.S.A. 8800 Walther Blvd., Apt. 3214 death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Depertment of Heelth and Mental Hygiene. Important: if tiem 27 is marked other than "natural; or item ony injury or other traumatic event, the Medical and Once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Broker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Crandall Gladys Von Cate Ernest 2 19b. Mailin, Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
421 Karkspur Drive Joppa, Maryland 21085 19a. Informant's Name/Relationship (Type, Print) Son Kenneth D. Brown Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Dulaney Valley Memorial Gardens other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4-14-2006 Maryland 4 ☐ Donation 5 ☐ Other (Specify) Timonium 21. 30 yeure van ral se vice Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final RESPIRATORY FAILURE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ISCHEMIC CARDIOMYOPATHY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed RENAL FAILURE Due to (or as a consequence of) Box 68760. SEPTIC SHOCK Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐Unknown LACTIC ACIDOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an CORONARY ARTERY DISEASE autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 <del>∏</del> № certificate CELLULITIS Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one director, Be Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No .Pis After this 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: 5 Pending investigation 1 ▼ Natural 2 Accident 1 Tyes 2 □ No death. Director; 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours efter 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Sich D 31826 which

State Registrar

DHMH 17 Rev 1/2001

7601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Dar) 32. Figistrar's Signature 1 1 2006

7601 OSLER DRIVE.

MARYLAND 21204

TOWSON,

			1 - For State Registrar	State of M	arylan		artmen rtificate			and Me	ental Hy	giene Reg. Na		6		195
Į.	Physici	an	1. Decedent's Name (First, Middle, L								2. Date of De Month	Da		ear (	3. Time o	_
	/Medic	al	Charles Joseph (  4a. Facility Name (If not institution, g				4h Cih	Town or	Location o		April	9,	2006 County of		3:20	A M
	Examin	er	Manor Care Health			ville		seda		Death			Balti		е	
-	Funeral Director	2	216 03 1156	Sex 7. Ag	ge (In yrs. 88	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. A	8. Date of Bir (Month, Da pril 2	th ay, Year, 6,19	17	Birthpl Coun Mary	lace (State of try) Land	or Foreign
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10	0d. Inside C	ity Limits
	a-f sh	ctor	Maryland Baltim	ore		Roseda.	le								1 🗌 Yes	2€ No
	h with th	ai Dire	10e. Street and Number 6710 Ridge Rd. "A	Apt.102"			10f. Zip	Code 212	37			10g. Ci	tizen of Wh	at Coun	try?	
0-00-0	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or Items 23e or 28e-f show event. Itse Madical Examiliar must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1. ∑Yes 2 ☐ If Yes, Give Year or Dates:	•		Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spec , Puerto R	cify Yes or No Rican, etc.)	0-	14. Race - Black, Specify:	White,	etc.	
<u>0</u>	natur	eted	15. Decedent's (Specify only highest of	Education grade completed)		16a. Dece (Give	dent's Usua kind of wor DO NOT us	d Occupa	ation during most	of workin	g	16b. H	(ind of Busi	ness/ind	lustry	
7	within 72 ene. then "nat	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Servi						Ut	ility	Con	pany	
פ	e filed al Hygid I other vent.	Be C	17. Father's Name (First, Middle, La	st)					18. Mothe	r's Name	(First, Middle	1			<u> </u>	
yland	2 should be and Mental Is marked o	To	Anthony Chase							a Die						
Mar	nd 2 sh lth and 27 is m traum		19a. Informant's Name/Relationship Charles M. Chase								Route Numb					
je,	of Heal		20a. Method of Disposition			Place of Dispo cemetery, crei	sition (Nan	ne of			ate		ocation - Ci			
Saltimor	Page ment cant: If	8	1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special	cify)		timore	Natio	onal	Cemet	_				svil	le, M	d.
Dall	permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked, ery Injury or other traumatic ev <u>once</u> .		21. Signatur of Funeral Service Lic	Rounko -		Į Į	2. Name an Bruzda 1 407 (	d Addres Zinsl	s of Facility Ki Full Faste	y neral rn Av	l Home zenue I	P.A	, x. Ma:	rvla	nd 21	221
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause ly one cause on each l	d the deat										Approxima Interval Be	te tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a End	ठो	ape	deu	rel	wtic	<u> </u>					Onset and	Death
	Examiner	33		Due to (or as	a conseq	uende of):										
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	bbue to (or as	a conseq	uence of):				•						
	xecute and	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseq	uence of);						-				
09/90	certificate be executed adding physicien and use as the burial-transit	icai E		d												
	ertifica ling ph e as th	Med	IF FEMALE:	00. 11										We see a see a see a see a see a see a see a see a see a see a see a see a see a see a see a see a see a see a		
C. DOX	death e etter	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	□Ectopic pr □ Other (sp			27112.202.202			23d. Date Month		,	Year
Ž.	requires that the een signed by th hould be detache	by Ph	Part II. Other significant conditions	contributing to death t	out not res	ulting in the u	nderlying c	ause give	en in Part I.		23e. Did	tobacco	use contrib	ute to th	e cause of	death?
cords	w requires that s been signed b should be deta		Ischemic	laidir	my	dogo	<u> </u>			<del></del>	1 🗆	Yes 2	□ No 3	☐ Prob	ably 4	Unknown
Œ)	e law has b	Completed			<u>'</u>						24a. Was auto perfe	psy ormed?	pride	or to con ath?	osy findings npletion of (	available cause of
	iician: Th certificate rector, pag	0	25. Was case referred to medical						26. Place	of Death	1 Yes	one)	11	] Yes	2□ No	
<u> </u>	S 5	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpati		ER/Outpatier		A Othe	Nu		ne 5□Res				')	
	ding h. After fune	tion:	27. Manner of Death  Natural 5 Pending investigat	28a. Date of Inju (Month, Da	iry iy Year)	28b. Time o Injury	f 2	8c. Injury Work	rat ⊲? Yes 2.⊟N		8d. Describe	how inju	ry occurred	1		
DIVISION	or Atten ifter deal Director in by the	ertification:	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be Oga Blace of In	jury - At h	ome, farm, str y)					8f. Location ( City or To			or Rura	l Route Nun	nber,
	4 HO	edicai C	25a Cartifier Check only 2 Medical Ex	Chyainian: To the best aminer: On the basis of and manner st	of examina	wledge deat ition and/or in	r usaumsd vestigation,	at the two	e, data and pinion, deat	d plane, at th occurre	nd dus to the id at the time,	cauca(c date an	d place, an	of ac et	ated: the cause(	s)
	To the Hos within 24 h To the Fur completely	Me	285. Signature and title of certifier				290		number			29d. Da	ate signed (	Month, I	Day, Year)	
	0		Mulu	MD					569	79					LOD	
1	11	1	Name and address of person wh	o completed cause of	death (Iter	s Da	Print)	1001	101	SI	- 1A)	6	الما	211	210	6/1
	Sta	te	31. Date filed (Month, Day, Year)	32 Registi	rar's Signa	ature	A		U		(100	J	ien 1	<b>1</b> 101	1	NO
	Registr	ar	NDD 1 1 1	anne les	1	X An	MAL									

DHMH 17 Rev 1/2001

The of Parth

L161/70/1/ 900

3511-50-115 N.S.

Charless Chase

			1_ For	State of Maryland / [				nd Men		2000	11096
	Α		1 - For State Registra Amend item #18  1. Decedent's Name (First, Middle, Last)	Per FH G854 4	Gertifica 11706	JH or i	Jeam	2 [	Reg	J. No.	3. Time of Death
	Physici	an	Margaret Virginia C					1	Month	Day Year 7, 2006	
1 14	/Medic Examin		4a. Facility Name (If not institution, give stre		4b. Ci	ty, Town, or	Location of [		TIT C	4c. County of Dea	10:40 A. <sup>M</sup>
数を	Lxamiii	CI	Manor Care Dulaney 1	Nursing Home		To	wson			Baltin	ore County
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last bir	Month	der 1 Year		Min.	ate of Birth Month, Day,	(ear) 9. Bii	thplace (State or Foreign
L	Director		214-03-0228 1 M	89	Yrs.			Ja	n.01,1	.917 Coc	keýsville,MD
	land ow		10a. State 10b. County	10c. City, Tow	n or Location						10d. Inside City Limits
	Mary	to	Maryland Baltimore	e County Timon	ium						1 ☐ Yes 2₺ No
	or 28s	lrec	10e. Street and Number			Zip Code			109	g. Citizen of What C	ountry?
	hours after death with the Maryland tursi', or Items 23a or 28a-f ahow al Exercinal must be notified at	Funeral Director	10 Hammen Ave.				21093			United S	States
	tems	nue		Was Decedent Ever in U.S. Armed Forces?	13. Was Dec If Yes, s	cedent of Hi pecify Cuba	ispanic Origin In, Mexican, F	n? (Specify Puerto Rica	Yes or No- n, etc.)	14. Race - Am Black, Whi	
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2X No If Yes, Give Year or Dates:	1 🗆 Yes	2 <b>₫</b> ₩0	Specify:			Specify: V	Mhite
21215-0036	2 hou	pel	15. Decedent's Educat	ion 16a.	Decedent's U	sual Occupa	ation		11	5b. Kind of Business	s/Industry
215	hin 7	ple	(Specify only highest grade of Elementary/Secondary (0-12)		(Give kind of life. DO NOT			f working			
	ed wit	Completed	0 /	College (1-4or 5+) Il/a	Toc	ol Mak				Black &	Decker
Ind	be file	Be	17. Father's Name (First, Middle, Last)						st, Middle, Ma <b>inia</b> Hed	aiden Sumame)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 ahow appringury or other traumatic event, the Madical Examinat must be notified at ance.	P_	William Harrison Cui	the state of the s	Adadima Adalas	on /Ctmate				City or Town, State,	Zin Codol
Mai	d 2 st th and 17 Is r traur		Mrs. Hilda M. Munme		1 Waugh				Maryla	-	
	Heal Heal tem 2		20a. Method of Disposition		f Disposition (A ry, crematory o		_	Date	20	oc. Location - City or	
υOπ	ages ent of nt: If I		1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State Popla	ry, crematory o r Grove	e Meth	.Cem.	April 2006		hoenix,Ma	ruland
Baltimore,	mit. F partme portar r injur		21. Signature of Funeral Service Licensee	0 - 1	22. Name	and Addres	s of Facility				
ä	Depa Depa Impo any i		Jeppey J.	Jav. In.	2325	York	Iterna Road	tives Timon	iuner ium, Ma	al&Cremat ryland 2	i893 <sup>Ctr.,P.A</sup>
	÷		23a. Par(1, Enter the disease, or complicat shock, or heart failure. List only one	ions that caused the death. Do	not enter the m	node of dyin	g, şuch as ca	rdiac or res	piratory arres	it,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Jac clus		mu					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence							
	LAAIIIIIICI	Ļ	Sequentially list conditions, b.	The state of the same of the s	-8						
	ed sit	nine	Sequential y list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as a consequence	or).						
2-	be executed icien and burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequence	of);						
992	ate be executed hysicien and he burial-transit	cai	d.								
9	tificate ig phy as the									-1	
Box	death certifica e attending ph id for use as th	N/N	230. was decedent pregnant	If yes, outcome of pregnancy  1 Live birth 2 Fetal death	3 ☐Ectopic	pregnancy				23d. Date of de	
	it the deatl by the atte tached for	sick	in the past 12 ponths? 1 □ Yes 2 □ No	4☐ Pregnant at time of death 9☐ Unknown	5 Dther					Month	Day Year
0.0		Physician/Med	9 Unknown		a tha contact in		in Danil		22a Did taha	and use contribute t	to the cause of death?
JS,	ires tha signed d be de	by	Part II. Other significant conditions contril	buting to death but not resulting if	n the underlying	g cause givi	en in Parti.		23e. Did toba	/_	Probably 4 Unknown
Records,	w requir been si should	Completed									
3ec	The law cate has page 2 s	E E			<del></del>				24a. Was an autopsy perform	prior to	completion of cause of
a			25. Was case referred to medical						1□ Yes 2	2No 1 □ Ye	s 2 No
Vital		o Be	examiner?  1 Yes 2 No	pital: 1 ☐ Inpatient 2 ☐ ER/Ou	utpatient 3	DOA Othe	ar:		eck only one	ce 6 ☐Other (Spe	ocitiv)
o		n: To		28a. Date of Injury 28b.	Time of	28c. Iniun	v at			injury occurred	эспу)
<u>o</u>	Attending r death. ector: After by the fune	atio	1 Netural 5 Pending 2 Accident investigation	(Month, Day Year)	njury M	Worl	k? Yes 2 ∐No				1
Division	l or Attendater deatl Director:	ertification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa	ırm, street, fact	ory, office			ocation (Stre		Rural Route Number,
Ö	italon rs aft ral Di	O									
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Examine)	ian: To the best of my knowledge : On the basis of examination an	e, death occurr d/or investigati	ed at the tin	ne, date and p pinion, death	place, and o	due to the cau	ise(s) and manner a e and place, and du	is stated. le to the cause(s)
	the I	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	e number		290	d. Date signed (Mon	th Day Year
	To To		Ash IJ. Ho	IL MO.		535	593		i.	1/10/06	
•	17		30 Name and address of person who comp	pleter rause of death (from 22a)	(Type Print)		1 2 .			1. 1.	
	5		Man Maine 7	oleted cause of death (Item 23a)	Suti	208	Tous	in M	10 2/2	104	
	Sta	te	/31. Date filed (Month, Day, Year)	32. Registrar's Signature	Agenta	A					
	Registr	ar	APR 1 1 2000	Dogwas A.	ANDERSO						

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Andrew James Crusse :40 با ( /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b-City, Town, or Location of Death Examiner HIM OVE da If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country)
Nov. 14, 1951 Maryland d. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 215-60-6293 Days Min 1⊠M 2□F Yrs. 54 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. Count 10d, Inside City Limits or 28a-f show the Medical Examiner must be notified at MD Baltimore Essex 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 922 Garden Drive 21221 238 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 (∑Nes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. "naturel", or items 11 Maritaf Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: SpecifyWhite þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if item 27 ie marked other then "na eny injury or other traumatic event, the Madic 2006. (Give kind of work done during most of working life. DO NOT use retired) Better Buildings Elementary/Secondary (0-12) College (1-4or 5+) Welder 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Andrew Crusse Marilyn E. Petty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Andrew Crusse /father 305 Magnolia Terrace Baltimore MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition \2∞6 Baltimore MD 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bayview Crematory 04/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 300 Mace Ave. Balto.MD Connelly Funeral Home of Essex Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physician: The law requires that the deeth certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Cher (specify) 9 Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes No 24a. Was an s certificete has t lirector, page 2 s autopsy 1 Yes 2 No within 24 hours efter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Pface of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No 1 Inpatient 1 Yes 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier Name a d address son who completed use of death (Item 23a) (Type, Print) Rosedal 10110 31. Date filed (Month, Day, Yea) 32. Registrar's Signature State Registrar 2006

		1 - For State Registra Amend Item #1  1. Decedent's Name (First, Middle, Last)	JULYA TEL FILGO	7) T T/ LT/ UUII		2. Date of Death Month	Day Year	3. Time of Death
Physici /Medic		Marguerite S. Cliff	ford				6, 2006	8:01 A.M
Examir		4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or Lo	cation of Death		4c. County of Dea	
		Gilchrist Hospice  5. Social Security Number 6. Sex	7. Age (In yrs. last t	TOW	SON Under 24 Hrs.	9 Date of Birth		re County
Funeral Director		220 <b>-</b> 28 <b>-</b> 1978	м 2\sqrt{9} F 74		Hours Min.	8. Date of Birth (Month, Day, Y Feb.06,1	932 Mar	thplace (State or Foreign ountry) Yland
11		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
ust be notified at	tor	Maryland Baltimore	e County   Lutl	nerville				1 ☐ Yes 2 No
100 0	Director	10e. Street and Number		10f. Zip Code		10g	. Citizen of What C	ountry?
	rail	44 Faraday Drive			093		United St	
	Funeral	11. Marital Status  1 Never Married 2 Married	Was Decedent Ever in U.S.     Armed Forces?     1 □ Yes 24 No	13. Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto	Rican, etc.)	14. Race - Am Black, Whi	
	by	3 ☐ Widowed ♣ ☑ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🗹 No	Specify:		Specify:	White
	Completed	15. Decedent's Educ (Specify only highest grade	eation 16 completed)	ia. Decedent's Usual Occupation (Give kind of work done durn life. DO NOT use retired)	n ing most of worki	ng 16	b. Kind of Business	s/Industry
	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)				Magici	200
	CO	12 17. Father's Name (First, Middle, Last)	n/a	Jazz Sing		(First, Middle, Ma	Musici	.all
	To Be		chaeffer		Winifred			
	۲	19a. Informant's Name/Relationship (Type Halford		9b. Mailing Address (Street and	Number or Rura	l Route Number, C	City or Town, State,	Zip Code)
		Ms. Sean <del>Slittord</del>	(Daughter)	44 Faraday Dri			, Marylan	
		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		of Disposition (Name of tery, crematory or other place)	1117	21 .	c. Location - City o	
		4 ☐ Donation 5 ☐ Other (Specify)	Evan	s Funeral Chap	, ,	100		11,Maryland
once.		21. Signature of Funeral Service License	f-gan	22. Name and Address Peaceful Al 2325 York R	ternativ oad Tim	es Funer onium, M	al&Cremat aryland	ion Ctr.,P. 21093
		23a. Part /Enterthe disease, r complice shock, or heart failure. Vist only on	cations that caused the death. De cause of each line.					Approximate Interval Between
1		Immediate Caule (Final disease or condition		smuching p				Onset and Death
cal		resulting in death)	Due to (or as a consequent	e of):		*		-
	<u>_</u>	Sequentially list conditions b	Due to (or as a consequence	e of):				
	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,-				
	Exa	resulting in death) Last	Due to (or as a consequence	e of):				
	cai	d						
	Med	IF FEMALE:						
	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea				23d. Date of de Month	olivery Day Year
	ysic	1 ☐ Yes 2 █No 9 ☐ Unknown	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)				
	by Physician/Med	Part II. Other significant conditions con	tributing to death but not resulting	g in the underlying cause given	in Part I.	23e. Did toba	cco use contribute	to the cause of death?
	ed b					1/X Yes	2 □ No 3 □ F	Probably 4 Unknown
	Completed					24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
	E O					performe	d? death?	
	Be (	25. Was case referred to medical examiner?			6. Place of Death	(Check only one)		
	၉	1 ☐ Yes 2 ☑ No		Outpatient 3 DOA Other:	-		ce 6 Other (Sp	ecity) MOY (4
	tion:	27. Manner of Death  Delta San Pending  Accident investigation	28a. Date of Injury (Month, Day Year) 28b	o. Time of 28c. Injury a Work?  M 1 ☐ Ye	s 2□No	28d. Describe how	injury occurred	
	fical	3 Suicide 6 Could not be	28e. Place of Injury - At home,					Rural Route Number,
	Certification:	4  Homicide	building, etc. (Specify)			City or Town,	State)	
	Medical (	(Check only 2 Medical Examin	ilcian. To the best of my knowled her: On the basis of examination	lgs, death occurred at the time, and/or investigation, in my opin	date and place, ion, death occurr	and due to the cau ed at the time, date	5e(5) and manner to e and place, and du	is stated. ie to the cause(s)
	Med	29b. Signature and title of certifier	and manner stated.	29c. License n	umber	290	1. Date signed (Mor	nth, Day, Year)
		Marl	und	D 58			PML 6.	
•						1		
completely filled in by the funeral director, page		30. Name and address of person who co	mpleted cause of death (Item 23)	a) (Type, Print)	-	1000	70.17	

		For State Registrar	State of I	Maryland / De	partment of F Certificate of			iene <sub>eg. No.</sub> 0 0 6	11099
N. P.		1. Decedent's Name (First, Middle	e, Last)				2. Date of Deat		3. Time of Death
Physic /Med			Raym				April	8, 200	
Exam	iner	4a. Facility Name (If not institution 827 N. Arling	ton Avenue,	Apt. 1009	Bal	timore  If Under 24 Hrs		4c. County of	N/A
Funera Directo		5. Social Security Number 220–24–2307	6. Sex 7. 1 M 2 □ F	Age (In yrs. last birthd	Months Days	Hours Min.		1929 S	Birthplace (State or Foreign Country)  South Carolina
7		Usual Residence of Decedent		,,			DER 17,	1/2/	outil outoillia
yland		10a. State 10b. County	,	10c. City, Town o	r Location				10d. Inside City Limits
Mar a-1-s	ctor	MD	N/A		Ba	ltimore			1 X Yes 2 □ No
or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wha	at Country?
ath w		827 N. Arling				21217		US	
er de Itams	Funerai	11. Marital Status	12. Was Decede Armed Force ried 1 TYYes 2	es?	<ol> <li>Was Decedent of h If Yes, specify Cub.</li> </ol>	dispanic Origin? (S an, Mexican, Puer	to Rican, etc.)		American Indian, White, etc.
0036 hours after death with the Maryland turel', or Itema 23e or 28e-1 show all Exercities at	by F	1 ☐ Never Married 2 ☐ Mar 3 XWidowed 4 ☐ Divorced	14 Who Circo	s: Korea	1 ☐ Yes 2 X No	Specify:		Specify:	Black
21215-003 sd within 72 hours giene. er then "naturel", (		15. Deceder	nt's Education	16a. De	ecedent's Usual Occup			16b. Kind of Busin	
within 72 one.	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-4	lii	live kind of work done te. DO NOT use retire	d) auring most or wo	огкинд		
21.	NO.	6			Machine 0	perator			nufacturer
be filed that Hygic dother.	Be (	17. Father's Name (First, Middle,	Last)			18. Mother's Na	me (First, Middle, I	Maiden Sumame)	unk.
Nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Marylar it of Health and Mental Hygiene. If I tem 27 is marked other than "naturel", or items 23e or 28a-1 show or other fraumatic event. If a Medical Exactions in an attachment and other fraumatic event.	P	unk.		Cros		<u> </u>			
Aar 2 sh and 1 s m		19a. Informant's Name/Relations			ailing Address (Street		0.0200000000000000000000000000000000000	4	
Te, M 1 and 2 Health tem 27		Jerry V. Cross 20a. Method of Disposition	s, son		10 Kirkwood	d Koad	Gwynn O	Oak, MD 20c. Location - Cit	21207 by or Town, State
Baltimore, permit. Pages 1 ar Department of Hea Important: If Item any injury or othe		1 Burial 2 Cremation		ate cemetery,	crematory or other pla				
ting it. Part in the state of t		4 □Donation 5 □Other (5			rematory, 22. Name and Addre			Baltimo	
Balt permit. Depart Import		Ven E	Manle				k Road B		of MD, Inc. , MD 21228
		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that cau	ised the death. Do not					Approximate Interval Between
Physician (cate be executed Examine physician and the burial-itansit expects)	1	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or c.	as a consequence of) as a consequence of) as a consequence of)		, Arte	y Diseo	ase	Onset and Death Years
I Records, P.O. Box 61 The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ☐ Fetal death nt at time of death	3 □Ectopic pregnanc 5 □ Other (specify) _	у		23d. Date o Month	
ds, P uires that usigned to signed to	d by P	Part II. Other significant conditions  Hypetens	ions contributing to deal	th but not resulting in th	ne underlying cause gr	ven in Part I.	23e. Did tol		ute to the cause of death?
f Vital Record ystclan: The law requir is certificate has been si director, page 2 should	Complete	Chromi re	nal fai	lure			24a. Was a autops perfort	sy prio me ? dea	re autopsy findings available or to completion of cause of th?
Vital F iclan: Th certificate rector, pag	Be (	25. Was case referred to medica examiner?			T-		ath Check only or	16)	
Division of Vital Records, To the Hospital or Attanding Physician: The law requires t within 24 hours after death. To the Funaral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be	2	1 ☐ Yes 2 No  27. Manper of Death 1 ANatural 5 ☐ Pendi	Hospital: 1 Inp 28a. Date of (Month, igation		ne of 28c. Inju	ry at	Home 5 Reside	ence 6 Other ow injury occurred	
Divis	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	mined 286. Place of	f Injury - At home, farm g, etc. <i>(Specify)</i>	, street, factory, office		28f. Location (S. City or Town		or Rural Route Number,
ne Hospit 124 hour ne Funare letely fille	edical (	29a. Certifier 1 Certifyi (Check only one) 1 Medica	ng Physicien: To the b I Examiner: On the bas and manne	is of examination and/or stated.	or investigation, in my	opinion, death occ	curred at the time, d	date and place, and	d due to the cause(s)
To th within To th comp	×	29b. Signature and little of certific	er DV	.0	29c. Licen	se number	2	29d. Date signed (	Month, Day, Year)
		moden	ch Blo	the My	) 1	050500		April	10,2006
1/2		30. Name and address of person	who completed cause	of death (Item 23a) (Ty	/pe, Print)	CL 1	0		1 1
"		Frederick B	- Fotler	IDNA	the Greene	>Trect	Daltim	re Mar	Month, Day, Year) 10, 2006  y land 21201
Regis	tate	31. Date filed (Month Pays Year	1 2006 32.	nistrar's Signature	Good				

			For State Registrar	State of Ma	rylan	•	artment of I		and Mer	-	giene Reg. Ne.	11116	Proprocessing of the second of	00
FE.S	Physici	- 0	1. Decedent's Name (First, Middle, Last)  Martha A	nn Cain	L					Date of De Month pril	Day	y Year	3. Time	of Death
	/Medic Examir	1	4a. Facility Name (If not institution, give s	treet and number)			4b. City, Town,	or Location o				County of Dea		
	Funeral Director	9	213-04-1070	M OFFE	(In yrs.	last birthday) Yrs.	Silver If Under 1 Year Months Days	If Under:	Min. 8.	Date of Bir (Month, Da	th y, Year)	Co	ry thplace (State buntry) yland	or Foreign
	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgomer	у		y, Town or Lo							10d. Inside (	City Limits
	h with the 23a or 28a st be not	Funeral Director	3815 Palmira Lane				10f. Zip Code 20906				-	izen of What Co ed Stat		
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Menhal Hygiene. I them 21 is marked other than "naturel; or items 23a or 28a-f show other traumatic event, the Marylan Exerciter must be notified at	þ	11. Marital Status  1 □ Never Married 2⊠ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decedent of fixes, specify Cub	oan, Mexican	gin? (Specif 1, Puerto Ric	y Yes or No an, etc.)	)-	14. Race - Ame Black, Whit Specify: W	e, etc.	
Maryland 21215-0036	filed within 72 ho Hygiene. Other than "natur ent, the Madical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		+)	Infor	dent's Usual Occu kind of work done DO NOT use reure mation T ecialist	during mos	t of working Logy			nd of Business. hnology		
land 2	should be filed and Mental Hygis marked other umatic event, III	To Be C	17. Father's Name (First, Middle, Last) William Robert	Gardner					or's Name (F Marth		, Maiden ythe	·		
Man	2 sho		19a. Informant's Name/Relationship (Typ				ng Address (Stree							
	Health Health tem 27 I		James A. Cain/Husba 20a. Method of Disposition	and	20b. P		Palmira sition (Name of natory or other pla		Silve pril <sup>Date</sup>			Mary La ocation - City or		06
E E			1 ⊠ Burial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			natory or other piz	1	[0, 20]	$\alpha \epsilon$	Bren	twood,	Marvla	nd
Baltimore,	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service License				Name and Addr OCKVILLE	-	Robe					
	Physician /Medical Examiner	Jer	23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	e cause on each lin	e. rian a conseq	Cance uence of):		ing, such as	cardiac or re	espiratory a	rrest,		Approxim interval Bio Onset and 2 yea:	etween d Death
68760,	death certificate be executed e attending physician and id for use as the burial-transit	dicai Examine	cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a conseq	uence of):								
.O. Box 6	that the death certificat led by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown	Bc. If yes, outcome  1 Live birth  4 Pregnant at 9 Unknown	2 🗌 Feta	Ideath 3[	Ectopic pregnand Other (specify) _	гу			:	23d. Date of de Month	livery Day	Year
rds, P	sigr sigr d be	þ	Part II. Other significant conditions con	tributing to death bu	it not res	ulting in the u	nderlying cause gi	iven in Part I.			_	use contribute to		
		Completed								24a. Was auto perfo 1 ☐ Yes	psy ormed?	24b. Were as prior to death?	utopsy finding completion of 2 No	s available cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:				hor:	of Death (C					
ō	ding h. After fune	ation: To	1  Yes 2  No	1 ∐ Inpatie 28a. Date of Injur (Month, Day		ER/Outpatier 28b. Time o Injury	28c. Inju		280	5½ Resi		6 □Other (Spe	icify)	
	in Die	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	iry - At ho	ome, farm, str	eet, factory, office		28f	. Location ( City or To		d Number or R	ural Route Nu	mber,
	To the Hospital or Atten within 24 hours after deal To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1½ Certifying Phys (Check only 2 Medical Examinone)	ician: To the best of ler: On the basis of and manner sta	examina	wledge, deat tion and/or in	vestigation, in my	opinion, dea	nd place, and oth occurred	due to the at the time,	date and	d place, and due	to the cause	
	To the within 2 To the complet	Σ	29b. Signature and title of certifier	P	-	5.	29c. Licen	ise number				te signed (Moni		
			30. Name and address of person who co	mpleted cause of d	eath (Iten	n 23a) (Tyne					Apri	1 7, 20	700	
-	10		Stephen P. Staal,					Mercl	nantil	e Lan	e, L	argo, M	D 2077	4
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)  APR 1 1 200	32 Pegistra	r's Signa									

			ate of Mary	land / Dep	or Print in I partment of	Health a	nd Mental	Hygiene		300 000	programme and	
		1- For State Registrar		Ce	ertificate of	Death			Reg. No.	20	U 5	
Physicia	n/	1. Decedent's Name (First, Middle	,Last)					2. Date of	Death		3	. Time of Deat
dical Examir		Linda Ma	rie	Drze	wiecki			Month April 10	), 2006	Year		4:38
		4a. Facility Name (if not institution		lumber)		b. City, Town, o	or Location of De	eath	40	. County of	Death	
) _		Franklin Square Hospit	tal			Rosedale			E	Baltimore	Coun	ty
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthday)	If Under 1 Ye		Hrs. 8. Date o	f 8irth (MM/	DD/YYYY)	9 Birthp Coun	
Director		217-50-1032	1 M 2 X F	57	Yrs.	Months Da	ys Hours	Min. 7/8	/1948	. 1		 Virgi
>-		Usual Residence of Decedent			_			,,,	, 1210			
* a		10a. State 10b. County		10c. Cit	ty, Town or Location	on						0d Inside City
rland -f shc	ğ		imore	M:	iddle Ri	ver						1 Yes 2
Mary 28a ed at	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citi:	zen of What	t Country	y?
h the 13a ol	百	605 Nollmeyer 1	Road			21220			II.	S. A.		
h wit	era	11. Marital Status		ecedent Ever in I Forces?		s Decedent of H es, specify Cuba	ispanic Origin?	(Specify Yes or		14. Race - A		n Indian, Blac
or it	ᆵ	1 Never Married 2 Mai	1 Yes	2 X No				ento Rican, etc.)		White,	etc.	
ral",	ρ		or Dates:		1	Yes 2 X N	o specify:			Specify:	Whit	e
DEMINITIONS, WID Z 12 12-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Education (Speci			16a. Decedent	's Usual Occupa	ation (Give kind	of work done	16b. k	Kind of 8usir	ness/Ind	ustry
n 72 lan "	olet	Elementary/Secondary (0-12)	College	(1-4 or 5+)		vorking life. DO	NOT use retired	d)				
Z1Z15-0036 zuld be filed within 7 l Mental Hygiene. marked other than ic event, the Medica	Ē	12			Homema]	ker				n Home	е	
filed Hyge of orth		17. Father's Name (First, Middle, L	.ast)				18 Mother's Na	ame (First, Midd	le, Maiden	Surname)		
d be fenta fenta narke	) Be	John Coley					Rita	Норе				
SALUMORE, MD 4  Permit. Pages 1 and 2 shou Department of Health and N  Important: If item 27 is in  jury or other traumatic	ို	19a. Informant's Name/Relationshi				Address (Street)		or Rural Route	Number, Ci	ty or Town,	State, Z	ip Code)
Physician / /Medical Examiner		23a Part I. Enter the disease, or of failure. List only one cause of Immediate Cause (Final disease)	n each line. a. <b>Compli</b> o	cations o	th. Do not enter the		, such as cardia	ac or respiratory	arrest, sho	ck, or heart		and 21 Approximate 8etween On Deat
		or condition resulting in death)	Due to (or as	a consequence	of):							
		Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence	of):							
	.⊑	if any, leading to immediate Due to (or as a consequence of):  cause. Enter Underlying Cause										
	Ε		(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
ed nsit	Exam	(Disease or injury that initiated		a consequence	of):							
xecuted n and rransit	Exam	(Disease or injury that initiated events resulting in death) Last	d.		•	~95/. /./2						
<b>U,</b> be executed  rsician and  burial - transit		(Disease or injury that initiated events resulting in death) Last			of): a,27,perME	,g854,4/2	4/06 TT					
ificate be executed ig physician and is the burial - transit		(Disease or injury that initiated events resulting in death) Last    X UNPENDED	d.  AMENDED  23c. If yes,	item#23e	a,27,perME	, .		grapa.		Date of de		. W
n certificate be executed ending physician and use as the burial - transit		(Disease or injury that initiated events resulting in death) Last  X UNPENDED  F FEMALE:	d. AMENDED  23c. If yes, 1 Live	item#23e	a,27,perME gnancy 2 Feta	al death 3	4/06 TT	gnancy		Date of de	elivery Day	Ye
death certificate be executed the attending physician and dor use as the burial - transit		(Disease or injury that initiated events resulting in death) Last    X UNPENDED	d.  AMENDED  23c. If yes, 1 Live 4 Preg	item#23a outcome of pred birth nant at time of d	a,27,perME gnancy 2 Feta	, .		gnancy				Ye
at the death certificate be executed the attending physician and arached for use as the burial - transit	Physician/Medical	(Disease or injury that initiated events resulting in death) Last  X UNPENDED  F FEMALE: 3b. Was decedent pregnant in the past 12 months?	d.  AMENDED  23c. If yes, 1 Live 4 Preg  nown 9 Unkr	item#23a outcome of prea birth nant at time of d	a,27,perME gnancy 2 Feta death 5 Oth	al death 3 er (Specify)	Ectopic pre			Month	Day	
y, r.v. bux volvu, res that the death certificate be executed signed by the attending physician and be detached for use as the burial - transit	Physician/Medical	(Disease or injury that initiated events resulting in death) Last  X UNPENDED  F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unkn	d.  AMENDED  23c. If yes, 1 Live 4 Preg  nown 9 Unkr	item#23a outcome of prea birth nant at time of d	a,27,perME gnancy 2 Feta death 5 Oth	al death 3 er (Specify)	Ectopic pre	23e. Di		Month use contribu	Day	cause of dea
requires that the death certificate be executed requires that the death certificate be executed been signed by the attending physician and rould be detached for use as the burial - transit	Physician/Medical	(Disease or injury that initiated events resulting in death) Last  X UNPENDED  F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unkn	d.  AMENDED  23c. If yes, 1 Live 4 Preg  nown 9 Unkr	item#23a outcome of prea birth nant at time of d	a,27,perME gnancy 2 Feta death 5 Oth	al death 3 er (Specify)	Ectopic pre	23e. Di 1 24a. W	d tobacco ι Yes 2 as an	Month use contribu	Day ute to the	cause of dea
Louds, F.C. BOX 80700,  I law requires that the death certificate be executed  has been signed by the attending physician and  e 2 should be detached for use as the burial - transit	Physician/Medical	(Disease or injury that initiated events resulting in death) Last  X UNPENDED  F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unkn	d.  AMENDED  23c. If yes, 1 Live 4 Preg  nown 9 Unkr	item#23a outcome of prea birth nant at time of d	a,27,perME gnancy 2 Feta death 5 Oth	al death 3 er (Specify)	Ectopic pre	23e. Di 1 24a. W	d tobacco u Yes 2 as an topsy	Month use contribu No 3 24b. Wei	Day ute to the Probab ere autopor to com	cause of dea ly 4 🗹 Unk sy findings av
TRECOLDS, P.O. BOX 68/00,  The law requires that the death certificate he executed freate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Physician/Medical	(Disease or injury that initiated events resulting in death) Last  X UNPENDED  F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unkn  Part II. Other significant conditio	d.  AMENDED  23c. If yes, 1 Live 4 Preg  nown 9 Unkr	item#23a outcome of prea birth nant at time of d	a,27,perME gnancy 2 Feta death 5 Oth	al death 3 er (Specify)	Ectopic pre	23e. Di 1 24a. W	d tobacco u Yes 2 as an topsy uformed?	Month use contribu No 3 24b. Wei	Day ute to the Probab ere autopor to com	cause of dea ly 4  Unk sy findings av pletion of cau
Ital Kecords, P.O. Box 68/60,  Idam: The law requires that the death certificate be executed  is certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial - transit	hysician/Medical	(Disease or injury that initiated events resulting in death) Last  X UNPENDED  F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unkn	d.  AMENDED  23c. If yes, 1 Live 4 Preg 9 Unkr	item#23coutcome of president in the present of the	a,27, perME gnancy 2 Feta death 5 Oth resulting in the un	al death 3 her (Specify) anderlying cause 26. Place	Ectopic pre	23e. Di 1 24a. W au pe 1 Ye eck only one)	d tobacco u Yes 2 as an topsy rformed? ss 2 No	Month use contribu No 3 24b. Wei prio dea 0 1	Day  Ite to the Probab  Probabere autopor to comath?  Yes	cause of dea ly 4  Unk sy findings av pletion of cau
I VITAI KECOTOS, P.O. BOX 68/60, Physician: The law requires that the death certificate be executed ar this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	(Disease or injury that initiated events resulting in death) Last  X UNPENDED  FFEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 V Unkn  Part II. Other significant condition  25 Was case referred to medical examiner?  1 Yes 2 No	d.  AMENDED  23c. If yes, 1 Live 4 Preg 9 Unkr	item#23c outcome of precipirth nant at time of d nown to death but not	a,27,perME gnancy 2 Feta death 5 Oth resulting in the ur	al death 3 her (Specify) anderlying cause 26.Plac 3 DOA	Ectopic pre given in Part I.  e of Death (Che Other4 Nu	23e. Di 1 24a. W au pe 1 ✓ Ye sck only one) rsing Home 5	d tobacco L Yes 2 as an topsy rformed? ss 2 Resider	Month use contribu No 3 24b. Wei prio dea 0 1   makes	Day  ute to the Probab ere autopor to com ath? Yes  Other	cause of dea ly 4  Unk sy findings av pletion of cau
n of Vital Records, P.O. Box 68760, ding Physician: The law requires that the death certificate be executed h After this certificate has been signed by the attending physician and finneral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	(Disease or injury that initiated events resulting in death) Last  X UNPENDED  F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkn Part II. Other significant condition  25 Was case referred to medical examiner?  1 Yes 2 No 9	d.  AMENDED  23c. If yes, 1 Live 4 Preg 9 Unkr  Ins contributing to  28a. Date (Mont)	item#23coutcome of president in the present of the	a,27, perME gnancy 2 Feta death 5 Oth resulting in the un	al death 3 her (Specify)  anderlying cause  26.Plac 3 DOA hury 28c. Inju	Ectopic pre given in Part I.  e of Death (Che Other <sub>4</sub> Nu	23e. Di 1 24a. W au pe 1 Ye eck only one)	d tobacco L Yes 2 as an topsy rformed? ss 2 Resider	Month use contribu No 3 24b. Wei prio dea 0 1   nce 6	Day  ute to the Probab ere autopor to com ath? Yes  Other	cause of dea ly 4  Unk sy findings av pletion of cau
Sion of Vital Records, P.O. Box 68760,  Attending Physician: The law requires that the death certificate be executed death retor. After this certificate has been signed by the attending physician and by the functal director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	(Disease or injury that initiated events resulting in death) Last  X UNPENDED  FFEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 ✓ Unkn  Part II. Other significant condition  25 Was case referred to medical examiner?  1 ✓ Yes 2 No  27. Manner of Death	d.  AMENDED  23c. If yes, 1 Live 4 Preg 9 Unkr  ons contributing to the contributing to the contributing to the contributing to the contributing to the contributing to the contributing to the contributing to the contributing to the contributing to the contributing to the contribution t	outcome of prediction of death but not linearly a linearly linearl	a,27, perME gnancy 2 Feta 5 Oth resulting in the ur  ER/Outpatient 28b. Time of Inj	al death 3 her (Specify)  aderlying cause  26.Plac  3 DOA houry 28c. Inju 1	Ectopic pre given in Part I.  e of Death (Che Other <sub>4</sub> Nu ury at Work? Yes 2 No	23e. Di 1 24a. W au pe 1 ✓ Ye sck only one) rsing Home 5	d tobacco L Yes 2 as an topsy rformed? ss 2 Resider	Month use contribu No 3 24b. Wei prio dea 0 1   nce 6	Day  ute to the Probab ere autopor to com ath? Yes  Other	cause of dea ly 4  Unk sy findings av pletion of cau
LIVISION Of VITAI RECORDS, P.O. BOX 68760, tall or Attending Physician: The law requires that the death certificate be executed as after death all Director. After this certificate has been signed by the attending physician and led in by the funeral director, page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	(Disease or injury that initiated events resulting in death) Last  X UNPENDED  F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkn Part II. Other significant condition  25 Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pendir 1. Pend	d.  AMENDED  23c. If yes, 1 Live 4 Preg 9 Unkr  ons contributing to 28a. Date (Mont) 1 gation 1 28a. Place 1	outcome of president process of the	a,27,perME gnancy 2 Feta death 5 Oth resulting in the ur	al death 3 her (Specify)  aderlying cause  26.Plac  3 DOA houry 28c. Inju 1	Ectopic pre given in Part I.  e of Death (Che Other <sub>4</sub> Nu ury at Work? Yes 2 No	23e. Di  1 24a. W au  1 Ye eck only one) rsing Home 5 28d Descrit 28f Locatio	d tobacco u Yes 2	Month use contribu No 3 24b. Wei prio dea 1  mce 6	Day  ute to the Probab ere autopor to com ath? Yes  Other	cause of dea ly 4  Unk sy findings av pletion of cau 2
DIVISION Of VITAI RECONDS, P.O. BOX 68760, spiral or Attending Physician: The law requires that the death certificate be executed blues after death reral Director. After this certificate has been signed by the attending physician and y filled in by the funeral director, page 2 should be deached for use as the burial - transition of the control of th	Certification: To Be Completed by Physician/Medical	(Disease or injury that initiated events resulting in death) Last  X UNPENDED  F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkn Part II. Other significant condition  25 Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pendir Investing Suicide 6 Could determ	d.  AMENDED  23c. If yes, 1 Live 4 Preg 9 Unkr  Ins contributing to the limit of th	outcome of president process of the	a,27, perME gnancy 2 Fets death 5 Oth resulting in the ur  ER/Outpatient 28b. Time of Inj	al death 3 her (Specify)  anderlying cause  26.Plac 3 DOA higher 28c. Injuny 1 c., factory, office in	Ectopic pre given in Part I.  e of Death (Che Other <sub>4</sub> Nu ıry at Work? Yes 2 No building, etc.	23e. Di 1 24a. W au pe 1 ✓ Ye sck only one) rsing Home 5 28d Descrit 28f Locatio or Towr	d tobacco u Yes 2 as an topsy rformed? Resider pe how inju n (Street ar	Month use contribu No 3 24b. Wei prio dea 0 1 v nce 6 0 ry occurred	Day ute to the Probab ere autopor to com ath? Yes Other	Ye cause of dea ly 4  Unk sy findings av pletion of cau
rispital or Attending Physician: The law requires that the death certificate be executhours after death nearly Director. After this certificate has been signed by the artending physician and filled in by the funeral director, page 2 should be detached for use as the burial - training the detached for use as the burial - training and the detached for use as the burial - training and the detached for use as the burial - training and the detached for use as the burial - training and training are detached for use as the burial - training and training are detached for use as the burial - training are detached for use as the burial - training are detached for use as the burial - training are detached for use as the burial - training are detached for use as the burial - training are detached for use as the burial - training are detached for use as the burial - training are detached for use as the burial - training are detached for use as the burial - training are detached for use as the burial - training are detached for use as the burial - training are detached for use as the burial - training are detached for use as the burial - training are detached for use as the burial - training are detached - training are de	Certification: To Be Completed by Physician/Medical	(Disease or injury that initiated events resulting in death) Last  X UNPENDED  F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkn Part II. Other significant condition  25 Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pendir Investing Suicide 6 Could determ 28. Certifier 1 Certifying Phy	d.  AMENDED  23c. If yes, 1 Live 4 Preg 9 Unkr  ons contributing to the service of the service o	outcome of president process of the	a,27, perME gnancy 2 Feta death 5 Oth resulting in the ur  ER/Outpatient 28b. Time of Inj	al death 3 her (Specify)  anderlying cause  26.Plac 3 DOA higher 28c. Injuny 1 december 28c. Injuny 28c. Injuny 1 december 28c. Injuny 1	e of Death (Che Other Nu In at Work? Yes 2 No building, etc.	23e. Di 1 24a. W au 1 Ye ck only one) rsing Home 5 28d Descrit 28f Locatio or Town	d tobacco u Yes 2 as an topsy rformed? rs 2 No Resider pe how inju n (Street ar n, State) ause(s) and	Month use contribu No 3 24b. Wei prio dea 0 1  v nce 6 0 ry occurred	Day  ute to the Probab ere autopor to com ath? Yes  Other	cause of dea
LIVISION OF VICE TRECORDS, P.O. BOX 65/60, supilar or Attending Physician: The law requires that the death certificate be executed as after death certificate be executered in the factor. After this certificate has been signed by the attending physician and y filled in by the funeral director, page 2 should be detached for use as the burial - transfer.	edical Certification: To Be Completed by Physician/Medical	(Disease or injury that initiated events resulting in death) Last  X UNPENDED  F FEMALE: 3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkn Part II. Other significant condition  25 Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pendir Investing Suicide 6 Could determ 28. Certifier 1 Certifying Phy	d.  AMENDED  23c. If yes, 1 Live 4 Preg 9 Unkr  ons contributing to the service of the service o	outcome of presibirth nant at time of dinown to death but not  Inpatient 2 of Injury h, Day, Year)  ce of Injury - At h	a,27, perME gnancy 2 Fets death 5 Oth resulting in the ur  ER/Outpatient 28b. Time of Inj	al death 3 her (Specify)  anderlying cause  26.Plac 3 DOA higher 28c. Injuny 1 december 28c. Injuny 28c. Injuny 1 december 28c. Injuny 1	e of Death (Che Other4 Nu  ry at Work? Yes 2 No building, etc.	23e. Di 1 24a. W au 1 Ye ck only one) rsing Home 5 28d Descrit 28f Locatio or Town	d tobacco u Yes 2 as an topsy fromed? ss 2 No Resider pe how inju n (Street ar n, State) ause(s) and atte and place	Month use contribu No 3 24b. Wei prio dea 0 1  v nce 6 0 ry occurred	Day  ute to the Probab  ere autopor to com  ath? Yes  Other	cause of dea

Registrar

State 31. Date filed (Month, Day Year) 1 1 2006 Signature

30. Name and address of person who completed cause of death (Item 23a)

Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

O.C.M.E.

April 11, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 5 per Th 2/54 4-21-06 vt.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6:35a. 2006 04 10 Mary Ethel Dorsey /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 4806 Valley Forge Randallstown 5. Social Security Number 11 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 XF Maryland Director 02-16-1932 218 - 24Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 77 is marked other than "natural", or iteme 23s or 28e-f shov traumatic avant, the Medical Examinar must be notified at 1 □Yes 2NNo Director Randallstown MD Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 4806 Valley Forge Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. African-1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: Completed by 3 XWidowed 4 □ Divorced American 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Rosewood State Hosp Nursing Assistant 11th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Dorothy Robinson Wilhelm H. Sands 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health a Important: If Itam 27 is any injury or other traconce. 107 Delrey Ave. Catonsville, MD 21228 Ruth M. Young/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/15/06 Randallstown, MD St. Thomas 22. Name and Address of Facility Wylie F/H PA of Balto. Co. 21. Signature of Funeral Source Licensee \$200 Liberty Rd., Randallstown, MD 21133 d. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute disease or condition resulting in death) MO /Medical Due to (or as a consequence of): Examiner It your transion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. à 1 Yes 2. No 3 Probably 4 Unknown Completed Hypen hirinamie 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 1 Yes certificate 2. No After this certifice funeral director, p or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Yes 2 No 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27, Manner of Death 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 029085 An-1 10 2000 Dece-I chouse 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) 2310 Old Gers Paper Enter a PACE 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR Registrar

		For State		State	of Ma	aryland	,	artmen rtificate				lental Hy	6.	.00	6	11103
		Registrar	. ( 4)				Ce	lilloati	9 01 1	Jeani		2. Date of D	Reg. No	0.		2 Time of Death
Physici		1. Decedent's Name (First, Middle Josef				5.	D	ELG	102	ICE		Month ,	Da		Year	3. Time of Death
/Medic Examin	_	4a. Facility Name (If not institution		street and nu	ımber)					Location of		11/ / / 4		c. County		
		Bon Secours Ho	spi	tal				Ra1	timo	re						
Funeral		5. Social Security Number	6. Sex		7. Age	e (In yrs. las	t birthday)	If Under	1 Year	If Under		8. Date of B (Month, D	irth		9. Birthp	place (State or Forei
Director		218-18-9242	1 🔀	M 2□ F	90		Yrs.	Months	Days	Hours	Min.	Oct.6				and
D.		Usual Residence of Decedent										000.0	,			
arylan show		10a. State 10b. County			j	10c. City,	Town or L	ocation							1	0d. Inside City Limi
Mar	to	Maryland Balt	imor	e		Balt	imore	9								1 ☐ Yes 2 🔯 N
r 28s	irec	10e. Street and Number						10f. Zip	Code				10g. C	itizen of V	Vhat Cour	ntry?
should be filed within 72 hours after death with the Maryland and Mental Hygiene. It marked to other than "natural", or items 23a or 28a-f show unastic event, Ira Madical Exeminar must be notified at	Funeral Director	5926 Hilltop Av	enu	e				21	207				U:	SA		
ms 2	Jer	11. Marital Status		12. Was Dec		Ever in U.S.	13.	Was Dece	ient of H	ispanic Ori	igin? (Spe	ecify Yes or N Rican, etc.)	0-			an Indian,
	F	1 ☐ Never Married 2 🔀 Mar.	ried	Armed F	2 🗆 N	lo						rican, etc.)			k, White,	
urs al',	by	3 ☐ Widowed 4 ☐ Divorced		If Yes, G Year or I		WWII		1 🗆 Yes	2KI No	Specify:				Specify	: W	Mite
2 ho	ted	15. Deceden			1		16a. Dece	dent's Usua	al Occup	ation	t of worki	ng.	16b. F	Kind of Bu	isiness/In	dustry
No. 7	pie	(Specify only highe Elementary/Secondary (0-12)	si grade	College		+)	life.	kind of wo DO NOT us	se retire	d)	i or work	ng .				
d d d	Completed	12			`	<u> </u>	Lett	er Ca	arri	er			P	osta]	L Ser	vice
T SHE	Be	17. Father's Name (First, Middle,	Last)							18. Mothe	er's Name	(First, Middle	e, Maidei	n Sumam	ө)	
Aents Aents rked tlc	ToE	Ralph DelGiudio	e							Ge1	somi	na (unl	k)			
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if Item 27 is marked other than enty injury or other traumatic event, Ital Manner.		19a. Informant's Name/Relations	hip (Ty	рө, Print)			19b. Maili	ng Address	(Street	and Numbe	er or Rura	al Route Num	ber, City	or Town,	State, Zip	Code)
aith a		Dorothy DelGiud	lice	-Wife			5926	Hillt	op A	Avenu	e; B	altimo	re, l	Mary	Land	21207
E E E		20a. Method of Disposition				20b. Pla	ce of Disp	osition (Nar	ne of	(a)		Date	20c. L	ocation -	City or To	own, State
Page ento nt: #		1 ⊠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		lemoval from	State						4/1	2/06	Wood	llawn	, Ma	ryland
artm ortar		21. Signature of Funeral Service		99 ~ )	_	1	2	2. Name an	d Addre	ss of Facili	ySte:	rling A	Asht	on So	hwab	Witzke
Departing on yield		O Jan	2	T. l	me	solu	ント	unera	1 Ho	ome o	f Car	tonsvi	lle,	Inc.	lo 1V	D 21228
_		23a. Part1. Enter the disease, or	compli	ications that	caused	the death.								SVIII		Approximate
		shock, or heart failure. List Immediate Cause (Final	only or	ne cause on				•								Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	_ a	)		PNUE a conseque		NIA								5 DA73
Examiner								0071	4	UE	OPT	DIS	r m n	< 4 <sup>-</sup>		UNKNON
	ā	Sequentially list conditions,	b			a conseque		12011		1 1 Par 1.	7/-/	2/3	E 17.	32		410/2/14
ted	i.	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<													
xecu and	Examiner	that initiated events resulting in death) Last	C	Due to	o (or as	a conseque	nce of):									
cete be executed physicien and the burial-transit	alE		l													
phys s the	dical			3												
certii oding	Physician/Me	IF FEMALE:	2	3c. If yes, or	utcome	of pregnance	y							23d Dat	e of deliv	arv
atter for u	ciar	23b. Was decedent pregnant in the past 12 months?				2 Fetal d		□Ectopic pr □ Other (sp		,				Мо		Day Year
the d	ıysi	1 □ Yes 2 □ No 9 □ Unknown		9□ Unki				,	,, _							
that that ed b		Part II. Dther significant conditi	ons cor	ntributing to	death bu	ut not result	ing in the u	inderlying o	ause giv	en in Part I	١.	23e. Did	tobacco	use cont	ribute to t	he cause of death?
uires sign d be	d by	URINARY	TR	ACT	IN.	FECT	ION					1 🗆	Yes 2	2 🗆 No	3 🗆 Prot	ably 4 ⊡túnknov
shou	Completed	4										24a. Wa	s an	24b \	Nere auto	ppsy findings availab
hes ye 2	Ę.	ANEMIA	- 4				0	0 =				aut	opsy formed?	_ 5	prior to co death?	mpletion of cause o
n: T icete r, pa		CHRO		12/21	NA2	- 7-1	1124	RE				1□ Yes	2 <b>P</b> N	0 1	Yes	2□ No
certil	o Be	25. Was case referred to medica examiner?	-	lospital:	1		2/0		Oth	00		Check only			- 15	
Tal di	-	1 Yes 2 No		28a. Date		nt 2 E	R/Outpatie 8b. Time o		28c. Injur	4 🗆 190		me 5 Res 28d. Describe				(y)
Affer and funding	fi	1 ☑Natural 5 ☐ Pendi		(Mo	nth, Day	y Year)	Injury	M	Wor	k? Yes 2□				.,		
then then death	ca	3 ☐ Suicide 6 ☐ Could	not be	28e Plac	e of Ini	ury - At hom	e farm el					28f. Location	(Street a	ind Numh	er or Rur	al Route Number,
Hospital or Attanding Physicien: The law requires that the death certific 4 hours after death.  Funeral Director: After this certificete hes been signed by the attending it lety filled in by the funeral director, page 2 should be detached for use as	Certification:	4  Homicide determ	nned	buile	ding, etc	c. (Specify)	-, 16/111, 31	. Journacion	y, United			City or To				
pital ours a eral filled		29a. Certifier 1 ☐ Certifyi	na Phys	sician: To th	ne best	of my know	edne dea	th occurred	at the tir	ne date ar	nd place	and due to the	e cause/	s) and ma	nner as s	tated
Hos Fun Fely	Icai	(Check only 2 Medical	Exami	ner: On the	basis of	examination	n and/or in	vestigation	in my o	pinion, dea	ath occurr	ed at the time	o, date ar	nd place,	and due t	o the cause(s)

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

SUDHIR . D . PATEL. 2000 W BALIO, ST, BALTU, MD. 32 Aegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BON SELOURS FLOSP.

MD.

29c. License number

D 23300

29d. Date signed (Month, Day, Year)

2006

APRIL

			i icase i	State of Maryland		ot of Health and		•	
			For State Registrar	orace of marytans	•	te of Death		Regi No. 006	1104
2	Physicia /Medic		1. Decedent's Name (First, Middle, Last,	Lee De P	board		2. Date of De	Pay DCOC	3. Time of Death  7. 40 / M
1	Examin	er	4a. Facility Name (If not institution, give	HOSPICE		Town, or Location of Deat	h '	BALTIN	
#	Funeral Director		5. Social Security Number 6. Se. 3/5-74-6803			r 1 Year If Under 24 Hrs	8. Date of Bir (Month, Date)	th 9. Bir	thplace (State or Foreign ountry)
	Maryland -f ehow lind at	tor	10a. State 10b. County	10c. City	y, Town or Location	PAL			10d. Inside City Limits
	th with the 23a or 28a	al Director	10e. Street and Number  7/6 Valley Bot	Hom Rd.	10f. Zi	2/00/		10g. Citizen of What C	ountry?
036	be filed within 72 hours after death with the Maryland at Hygiene. A letter the "result of the then "returnal", or items 23a or 28a-f ehow of other then "returnal Examination and event, the Medical Examination in the notified at	by Funeral	11. Marital Status  1 Vever Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	S. 13. Was Dece If Yes, spe 1 \( \triangle Yes	edent of Hispanic Origin? (Socity Cuban, Mexican, Puer 2 Po No Specify:	pecify Yes or No to Rican, etc.)	14. Race - Am Black, Whi	
9500-6121	within 72 ho ene. then "natur to Medical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		16a. Decedent's Usu (Give kind of w life. DO NOT	ork done during most of wo use retired)	rking	16b. Kind of Business	/Industry
yland 2	be d its d	To Be Co	17. Father's Name (First, Middle, Last) RALIVMONA B. L	So Board.	Discon		me (First, Middle	, Maiden Surname)	
Mary	2		19a. Info ant's Name/Relationship (T)	Nother	19b. Mailing Addres	s (Street and Number or R	ural Route Numb	ner, City or Town, State,	Zip Code)
nore,	9 0 <u> </u>		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State	lace of Disposition (Na emetery, crematory or	12 0 M 1	Sate /	20c. Location - City or	- 1// 0
Baltimore,	permit. Pag Department Important: eny injury c		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens		22. Name a		4/13/06 DEST /	HILL, MO 2	CHOUSE PRE
· 影点			23a. Part1. Enter the disease or compleshock, or heart failure. List only o	cations that caused the death se cause on each line.	n. Do not enter the mo	de of dying, such as cardia	c or respiratory a	irrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ					
Se'	Examiner	Jer	Sequentially list conditions,	Due to for as a consequ	uence of):				
/60,	be executed sicien and burial-transit	ai Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of);				
9	# % e	ledicai		1				= = [ ] = = = = = = = = = = = = = = = =	
O. Box	The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	I death 3 Ectopic p			23d. Date of de Month	livery Day Year
1	w requires that the de been signed by the s should be detached f	þ	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the underlying	cause given in Part I.		tobacco use contribute to	o the cause of death?
Il Kecords,		Completed					24a. Was auto perfe 1  Yes	psy prior to death?	utopsy findings available completion of cause of
VII	ıysician: Th ııs certificate director, paç	Be	25. Was case referred to medical examiner?	lospital:			ath Check only		
lon of	ding Ph I. After th funeral	ation: To	1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatient 3 D  28b. Time of Injury  M	OA 4 Nursing H 28c. Injury at Work? 1 Yes 2 No	28d. Describe	dence 6 X Other (Spe how injury occurred	HOSPICE
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the to	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, facto	ry, office	28f. Location ( City or To	Street and Number or R wn, State)	ural Route Number,
	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medicai	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami	sician: To the best of my knowner: On the basis of examinat and manner stated.	wledge, death occurred tion and/or investigation	d at the time, date and place n, in my opinion, death occi	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To th within To th comp	Me	29b. Signature and title of certifier		25	c. License number		29d. Date signed (Mon.	th, Day, Year)
	11		1-			173725		4/10/0	16
	K		30. Name and address of person who co  DR. TARIO MAHMOOI	2300 DULANE	Y VALLEY R	D. TIMONIUM	, MD 210	193	
100 mg	Sta Registr		21 Date filed (Month Day Vest)	32 Registrar's Signa	Y VALLEY R	,			

DHMH 17 Rev 1/2001

7:40 p.m.

APRIL 9, 2006

DANIEL DEBOARD

Please Type or Print in Black Indelible Ink

1 100	ase type of the	III DIACK IIIGCI	IDIC IIIK
State of Mar	yland / Departm	nent of Health and	l Mental Hygiene

Physician/
Medical Examiner
>

Funeral Director

Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

	1- For State	Ce	rtificate of	Death				Reg N	20	116	11100
/ er	Registrar  1. Decedent's Name (First, Middle,Last)	Kalvin D	wojewsk	i			2. Date of Month April	_	Year		ime of Death
ı	4a. Facility Name (if not institution, give street 298 East Main street	and number)	4	b. City, Tov Westm		ation of De VID 2115		.4	lc. County of Carroll	Death	
7	5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under	1 Year I	f Under 24	Hrs. 8. Date	of Birth (MI	M/DD/YYYY)		ce (State or Foreign
	219-82-9878 1XXM 2	F 31	Yrs.	Months	Days	Hours I	Jun	e 29,	1974	Nort	h Carolina
	Usual Residence of Decedent  10a. State  10b. County	10c. City	, Town or Locati	on						10d	. Inside City Limits  Yes 2 XNo
5	Maryland Carroll					Wes	stmins				163 2 2110
حوسالمادوم ما المسودها فسودوا	10e. Street and Number  56½ John Street			10f. Zip C		157			itizen of Wha nited	_	s
		Vas Decedent Ever in Urmed Forces?  Yes 2 X No					( Specify <b>Y</b> es erto Rican, et		14 Race - White		ndian, Black,
	3 Widowed 4 Divorced If Yes,	Give Year	1	Yes 2	X No s	pecify.			Specify		White
	or Date 15. Decedent's Education (Specify only high		16a, Deceden	's Usual O	cupation	(Give kind	of work done	16b	Kind of Bus		
	Elementary/Secondary (0-12) Co	bllege (1-4 or 5+)		vorking life. truct		_			Cons	truct	ion
	17. Father's Name (First, Middle, Last)		COLLE	01 400	1		me (First, Mi	iddle Maide	n Surname)		
	Donald A. Dwojewsk:	Sr			10.1	MULIOI S INC	Jill				
	19a. Informant's Name/Relationship (Type, Pr		10h Mailina	Address	(Street or	d Number	or Rural Rou			State 7in	Code)
	Mr. Donald Dwojewsk	i, Jr.	306	Barks	dale	Road	Jopp	a, Ma	ryland	210	85
	20a. Method of Disposition  1 Burial 2 X Cremation 3 Re	moval from State	Place of Dispos crematory or oth . 11top S	er place)			Date /10/20		. Location - $\Gamma$ OWSON		
	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	\ \ \	22. N Du	ame and Add Add Add	dress of CK Fi	Facility In <b>er</b> a	1 Home	of D	undalk	, Inc	
	23a. Part I. Enter the disease, or complication	s that caused the death	1				Oundal ? ac or respirato	•	-	rt A	oproximate Interval
		cotic and coc		xicati	on					8	etween Onset and Death
	Sequentially list conditions, b.	(or as a consequence of									
	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	(or as a consequence of	of):								
		NDED item # 2	23a,27,28a	-f,per	ME,G85	54,4/17	7/06 TT				
	23b. Was decedent pregnant in the	If yes, outcome of preg		tal death	3 🔲	Ectopic pre	egnancy	2	3d. Date of o	delivery Day	Year
	past 12 months?  1 Yes 2 No 9 Unknown 9	Pregnant at time of de	anth	ner (Specif							
	Part II. Other significant conditions contri	□ buting to death but not r	resulting in the u	nderlying c	ause give	n in Part I.	23e.	Did tobacc			ause of death?
							24a.	. Was an	24b. W	ere autops	y findings available
							1 🗸	autopsy performed Yes 2	? de	or to compleath?  ✓ Yes	letion of cause of
	25. Was case referred to medical			26	Place of	Death (Che	eck only one)				
	examiner? 1 ✓ Yes 2 No	Impatient 2	ER/Outpatient				ursing Home		dence 6		ene
	T Cliding E	a, Date of Injury (Month, Day, Year) Inknown nd 4/3/2006	28b. Time of In Unknown Fnd 1:05		c. Injury a 1 Yes	XX No	Unknow		nju <b>ry</b> occurre	d	
	3 Suicide 6 X Could not be 2	Be. Place of Injury - At h		et, factory, o	ffice build	ing, etc.			and Numbe	r or Rural R <b>st Mair</b>	oute Number, City Street
	29a. Certifier (Check only one) 1 Certifying Physician: To Medical Examiner: On the	e basis of examination a	_				and due to th	ie cause(s)	and manner	as started.	
	and no 29b. Signature and title of certifier	nanner stated		29c. l	icense nu	ımber		290	. Date signe	d (Month, L	Da <b>y</b> , Year)
	Calcul	A.			D.C.M.I	Ξ		Ap	oril 3, 200	6	
	30. Name and address of person who complete Zabiullah Ali, M.D. Assistan	ted cause of death (Item t Medical Examine		nn Street	, Baltim	ore, MD	21201				
te ar	Zabiullah Ali, M.D. Assistan  31. Date filed (Month, Day, Year)  APR 1 1 2006	32 Registrar's Signat			, Baltim	ore, MD	21201				

ORIGINAL

Regist

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month April Day **Physician** 9, 2006 8:20p M Joseph Lonnie Eastin, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 505 Timberwoods Court Gambrills If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) July 17,1938 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Louisiana Director 427-68-0526 67 Usual Residence of Decedent 10b. County 10c. City, Town or Location **ehow** 10d. Inside City Limits ?7 is marked other then "natural", or items 23e or 28e-f ebov treumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 505 Timberwoods Court 21054 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 72 hours atter 1 ☐ Yes 2 No If Yes, Give 1 Never Married 27 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i Hygiene. other then Elementary/Secondary (0-12) College (1-4or 5+) 5+ Electrical Engineer Northrup Grumman permit. Pages 1 end 2 should be tile Department of Health and Mental Hy Important: if Item 27 is marked oth any lilury or other treumatic event ang. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ည Ford Emory Eastin Dorothea Felix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 Timberwoods Court Gambrills, Maryland 21054 Bessie Ruth Eastin/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Nichols-Bethel Cemetery 4/13/2006 Odenton, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, Manita 1411 Annapolis Road Odenton, Maryland 21113 nomas 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Smal /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit be executed Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. ф 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? 1 Yes Division of Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 1 ☐ Yes \_2 No ٩ 3 DOA Residence 6 Other (Specify) s etter death.
If Director: Atter this
of in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. escribe how injury occurred 1 Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medicai 29b. Signature and title of certifier 29c. License number PSZ830 anu wer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 900 Bestagte Road #3 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 1 1 2006

DHMH 17 Rev 1/2001

Registrar

1 For		State of I		d / Depa	artment	of He	ealth a	and M		ygie	ne	06	• Western	LIOR		
	State Registrar			Certificate of Death					0.0-1	Reg	No.	UU		1 1 0 0		
Dhysisian	Decedent's Name (First, Middle, Las.  Clemm		·		rvin				2. Date of D Month 4	8	Day	2006°		3. Time of Death 9:05p M		
Examiner 4a. Facility N	ame (If not institution, given 7 Ancon Ct.	re street and number	t and number)			4b. City, Town, or Location of Death  Edgewood						ounty of De Jarfor				
		Sex 7. Age (In yrs. last birthda								Birth 9. Birthpla Country				e (State or Foreign Md.		
9	ance of Decedent 10b. County			, Town or Lo	cation								10d	. Inside City Limits		
DI-cctor 10e. Street at 10e. Street	Md. Harford Edgewood  10e. Street and Number 10f. Zip Code							Y☐ Yes 2☐ 10g. Citizen of What Country?								
2927	2927 Ancon Ct. 21040								3	US						
utter death value 23 1 New 23 1 New 23 1 New 23	11 Marital Status 12. Was Decedent Ever in															
De Street a completed by Funeral Director  Be Completed by Funeral Director  Be Completed by Funeral Director  Be Completed by Funeral Director  10a. State  10b. Street a constant of them 23a or 28a-1 ehow  10b. Street a constant of them 23a or 28a-1 ehow  10c. Street a constant of them 23a or 2	or Married 2 Married	Armed Force 1 X Yes 2   If Yes, Give	XYes 2 □ No			If Yes, specify Cuban, Mexican, Puerto Ric  1 ☐ Yes 2 No Specify:				can, etc.)			Black, White, etc.  Specify: Black			
Maryland 21215-0036  d 2 should be filed within 72 hours aft d 2 should be filed within 72 hours aft th and Mental Hygiene. To Be Completed Evant To Be Completed by F  To Be Completed by F  To Be Completed by F	15. Decedent's Education (Specify only highest grade completed)			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)						168	16b. Kind of Business/Industry					
Table 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Elementary/Secondary (0-12) College (1-4or 5+)  12th grade			Staff Sargent						Military						
A Batheria Hymeria Hym	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)															
ROP  Roy  19a. Inform.  19a. Inform.  Timm  Co.  19a. Inform.  Timm  20a. Method	ant's Name/Relationship (	Type, Print)	~		ng Address (	Street a			Al Route Num	ber, C		-	n, State, Zip Code)			
	Ervin	Brother		2927	Ancor	n Ct	., E	dgewo	ood, Mo	đ.	21	040				
20a. Method	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - Commetery, crematory or other place)							=175	ity or Town, State							
Baltimore, Permit: Pages 1 at 1 and	4 Donation 5 Other (Specify)  Garrison Forest Vet. 4-18-06 Owings  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Baltimo  March F.H. East 1101 F. North								more	Mills, Md. e, Md. 21202 Ave.						
Physician / Medical Examiner  Sequentially if any, leading cause. Enter Cause (Dise that initiated resulting in the cause (Dise that initiated resulting in the cause (Dise that initiated resulting in the cause (Dise that initiated resulting in the cause (Dise that initiated resulting in the cause (Dise that initiated resulting in the cause (Dise that initiated resulting in the cause (Dise that initiated resulting in the cause (Dise that initiated resulting in the cause (Dise that initiated resulting in the cause).	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									Ir	pproximate interval Between on set and Death					
BOX Ge and certific death certific death certific and the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							23d. Date of delivery  Month Day Year								
bed bed	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 □ Unknown									
								24a. Wa aut per 1  Yes	prior to completion of cause of death?							
25. Was cas examine	25. Was case referred to medical an examiner? 26. Place of Death (Check only one)															
% v o l □ Yes	1 Tes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred															
nding ath. Tales of tune of tu	ral 5 Pending	(Month,	(Month, Day Year) Injury Work?  M 1 ☐ Yes 2 ☐ No						200. December non injury seconds							
Division of tall or Attaching Phy rate of attaching Phy rate of a steel death.  In or Attaching Phy rate of the funeral of in by the funeral of in by the funeral of in Phy rate of in Day the funeral of	cide 6 Could not b							28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Hospital Hos	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.															
29b. Signature and title of certifier  29c. License number  29d. C  29b. Signature and title of certifier  29d. C  29c. License number  29d. C  29c. License numb								11	Date signed (Month, Day, Year)							
6 X 30. Name at	nd a dress of person	completed cause of	BALT	23a) (Type,		Cī	R.	101	With	GH	es	ie S	the	ret-		
State Registrar APR 1 1 2006 32. Registrar's Signature																

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1, Decedent's Name (First, Middle, Last) Year 6:25 AM Bay Bay **Physician** 2006 6. ABEL /Medical 4a. Facility Name (If not institution, give street and nymber) 4c. County of Death 4b. City, Town, or Location of Death Examiner SALTIMORE KOSSUILLE KOSSUILLE CARE MANOR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Hours Min. Months Days MARYLAND 1 M 2 1 10 219-32-5683 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 27 is marked othar than "natural", or Itams 23a or 28a-f ahow traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director BALTIMORE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA APT 21236 DUNHAVEN LACE 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Affiled Polices
1 ☐ Yes 2 ☐
If Yes, Give
Year or Dates: 2 - No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify 3 ☐ Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic even" College (1-4or 5+) Elementary/Secondary (0-12) FIELD NURSE MEDICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be M. STANLEY MYYERS IHERESA 2 19b. Mailing Address (Street and Number, Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BACTIMORE, MD 20b. Place of Disposition (Name of cametery, crematory or other place) SPOJSE PLACE 20a. Method of Disposition Date 20c. Location - City or Town, State ADRIL 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BALTEMORE MD 12,2006 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 800 HARFORD RU CHAPEL PARKVICCE MD 21784 FUNERAL 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final snew Las Physician disease or condition resulting in death) /Medical Examiner risso vornile Sequentially list conditions, in any, reading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a curisequence or). Examiner Ay partien 8m Hospital or Attanding Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical for use as the remark inth IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed it page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown omt Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 2 HNo funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

within 24 hours after deat To tha Funeral Diractor: filled in by

Medical

29a. Certifier

(Check only one)

29b. Signature and title of eartifier

Registrar

32 Registrar's Signature

MD

29c. License number D 31469

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 0

410

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHAA11? A HASHMI. & 2( N. Entern St Smite 308, BALTIMORE MP 4120.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 915 **Physician** 2000 /Medical 4c. County of Death 4b. City, Town, or Location of Death Name-(If not institution, give street and number) Examiner aLTIMORE
1 Year | If Under 24 Hrs. | 8. Da Age (In yrs Date of Birth Month, Day, Birthplace (State Social Security Number 6. Sex **Funeral** Days Hours 1 □ M 2**X**21 F - 7671 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1X Yes 2□No Director Timore 108 Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 10 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Items 72 hours after 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 💥 No Specify: Specify: þ ac 3 Widowed 4 Divorced "natural", Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "rapy injury or other traumatic event, in a M. 4002. Elementary/Secondary (0-12) College (1-4or 5+) Inknown 10 Known Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Inknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11 Cir aptaol MZ1133 20c. Location - City r Town, State Benjamin 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or oth Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) altimore 1 21. Signature of Funeral Service Licensee 23a. Part . Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Pnysician Meummia 1 HK disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uscass of highly that initiated events Due to (or as a consequence of): Examiner certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): the attending physician Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ penipheral antenial Demention disease 1 Yes 2 No 3 Probably 4 Unknown Completed Hypertonslay wethe hooms 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? yes 2 12 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 2 1 ☐ Yes 2 🖫 No 1 Inpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manger of Death 28d. Describe how injury occurred Hospital or Attending P.
 A hours after death.
 Funeral Director: After the second of the Certification: 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier To the l within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D 30494 4-6-00 Balmore MD 21118 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DIE Maiden choice land KOESH MD

DHMH 17 Rev 1/2001

State Registrar 31. Date liled (Month, Day, Year)

APR 1

2006

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 4:20 A M April 7, Carolyn S. Eustice 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🖾 F 219-34-0386 93 Director April 23, 1912 0klahoma Usual Residence of Decedent Maryland 10a State 10b. County 10c, City, Town or Location 10d Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or items 23a or 28a-f show amp injury or other traumatic event, the Medical Exar. Lear must be notified at once. 1 Yes 2 No Director Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1235 Potomac Valley Road 20850 United States Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married ☐Yes 21 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ğ Specify: White 3 ₩ Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Catholic Charities 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles Τ. Stewart Margaret O'Brien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 West Pennsylvania Avenue, Towson, MD 21204 Wilbur C. Jensen/Attorney 20b. Place of Disposition (Name of Dulaney Crematory or other place)

Dulaney Valley

Memorial Garden 20a. Method of Disposition 20c. Location - City or Town, State April 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10, 2006 Timonium, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, MD 20850 21. Signature of Funeral Service Licensee M00092 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner nows neumoni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ettending physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ ete hes been signi page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 € No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificete director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) his funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending death. 1 Yes 2 No after death. investigation ξ 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funers! L 23s Conffie Certifying Physician: To the basis of my knowledge death occurred at the time date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai completely (Check only one) 29d. Date, signed (Month, Day, Year) 29b. Signature and title of certifier. 20062435

Registrar

State

50400

31. Date filed (Month, Day, Year)

9715

(Type, Print) (Pitter Dr. Rockville, MI) 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GIM

32. Registrar's Signature

ELSOYYOU

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) April 08, Physician 2006 7:20 A. M Dorothy India Frock /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Manchester
Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) Longview Nursing Home Carroll Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1 ☐ M 2 □ XF 214-30-5058 90 Director November 14,1915 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28e-f show the Medical Examiner must be notified at 1 ☐ Yes ¾☐ No Be Completed by Funeral Director Maryland | Carroll Manchester 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 238 4983 Wentz Road 21102 United States of America filed within 72 hours after death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: White 3 ₩ Widowed 4 □ Divorced 'natural' 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Home Maker Own Home 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is marked oth any linity or other traumatic event once. Eisenhart, Sr. Lillian Prager 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Daughter) 4983 Wentz Road, Manchester, Maryland 21102 Mrs. Margaret Sigmon 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Lorraine Park Cemetery 04/12/06 Woodlawn, Maryland 21207 \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, In 21. Signature of Funeral Service Licensee allner 400333 8728 Liberty Road, Randallstown, Maryland 21133 23a (Part). Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) siration **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence 61) Examine sician and e burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence ol) Box 68760. Physician/Medicai the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Records, P.O. ģ 23e. Did tobacco use contribute to the cause of death? signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No certificate 1 Yes Division of Vital o the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes No 2 ER/Outpatient 3 DOA 1 Inpatient 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. 28d. Describe how injury occurred 27. Manner of Death Injury at Work? Certification; After 1 Natural 2 Accident Injun 5 Pending 1 Yes 2 No death. investigation Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and title of certifier H0061206

Registrar

State

30. Name and address of person who completed cau

2006

31. Date liled (Month, Day, Year)

e of death (Item 23a) (Type, Print)

2. Registrar's Signature

		1 - State Amend Items 2	State of Maryland / Department of Head 3a, Pt 1,11,25,27,28a-f per M	alth and Mental Hygiene E. <b>C854, 04/05/06dhb</b> eath Reg. No.	006     3
Physic /Med		1. Decedent's Name (First, Middle, Last)	Grab	2. Date of Death Month Day MARCH	3. Time of Death 13,37 M
Exami Funeral Director	ner	5. Social Security Number 6. Sex	US HOSPITAL BALTMON	Action of Death  Action	9. Birthplace (State or Foreign Country)  Germany
the Maryland 28s-f show	rector	Usual Residence of Decedent  10a. State 10b. County  PA  York  10e. Street and Number	10c. City, Town or Location  Volume  10f. Zip Code	10g. Citiz	10d. Inside City Limits 1 ☐ Yes 2 No en of What Country?
Baltimore, Maryland 21213-0030  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at	by Funeral Director		1 Tyes 2 XNo	anic Origin? (Specify Yes or No- Mexican, Puerto Rican, etc.)	4. Race - American Indian, Black, White, etc.
d 21215-UU36 filed within 72 hours aff Hygiene "natural", or oth, the Medical Exam	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)  (Give kind of work done durilife. DO NOT use retired)  College (1-4or 5+)	ing most of warking	d of Business/Industry
Maryland d 2 should be file th and Mental Hy ?? Is marked oth traumatic event	To Be		nniq	8. Mother's Name (First, Middle, Maiden S Maria End d Number or Rural Route Number, City or	res
Baltimore, Mar permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 1s m any injury or other traum		19a. Informant's Name/Relationship (Type Charles M. Grand 20a. Method of Disposition 1 Burial 2 Cremation 3 Resident 1 Donation 5 Other (Specify)	Spouse 3150 West  20b. Place of Disposition (Name of complete or c	Market St You	ation - City or Town, State
Balti permit. Departri Importa any inju		21. Signature of Europeral Service Lice Serv	e 22. Name and Address C	of Facility Charles 1	Bother altri
Fnysiciar /Medica Examined		23a. Part I Enter the disease, or complic speck, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (gras a consequence of):	×	Approximate Interval Between Onset and Death O
Box 68760, sath certificate be executed attending physician and for use as the buriat-transit	dical Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of):	AWL AMPROVED BY JICAL	
the d	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	Bc. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)		3d. Date of delivery Month Day Year
COTGS, P. Cords, P. Cords, P. Cords that the bear signed by should be detacted.	þ.	Part II. Other significant conditions con Chronic uyeloid leul	tributing to death but not resulting in the underlying cause given kenia	in Part I. 23e. Did tobacco u: 1 ☐ Yes 2 <b>5</b>	se contribute to the cause of death?  No 3 Probably 4 Unknown
	Completed			24a. Was an autopsy performed?/ 1 □ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☑ No
of Vita physicien: this certific al director,	To Be	25. Was case referred to medical examiner?	ospital: 1 Impatient 2 ER/Outpatient 3 DOA Other:	26. Place of Death (Check onl. one 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6	
On O ding Ph th. After th funeral	tion;	27. Manner of Death   Natural 5   Pending     Accident   investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury a Work? Unknown	28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury 28d. Describe how injury	
Division of Vita Withe Hospital or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  At home	City or Tourn State	rket St., York, PA
Hospit 24 hours Funere	Medical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	<ul> <li>cician: To the best of my knowledge, death occurred at the time ner: On the basis of examination and/or investigation, in my opin and manner stated.</li> </ul>	, date and place, and due to the cause(s) nion, death occurred at the time, date and	and manner as stated. place, and due to the cause(s)
To the I within 2 To the Complet	Mec	29b. Signature and title of certifier	Medical Doctor RE	29d. Dat	e signed (Month, Dey, Year) YCh 17, 2006
6		30. Name and address of person who co	mpleted cause of death (Hem 23a) (Type, Print)  TY, M.D. GOI N. Caroline Street	Baltimore, Maryland	21287
Regis	state	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Andrew Barthage Bart	

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23a, PtI, 25, 27, 28a-f per ME G854, 04/10/06dhb
Pt II Certificate of Death For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Germia **Physician** -woncis corvary 05 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAITINUTE HO OKINS HO ) Ohns PITA 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Days Hours Min. 1⊠M 2□F Yrs. 218-44-5847 Director 61 1944 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location ir than "natural", or Itema 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 🙀 No Maryland Baltimore <u>Catonsville</u> Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 929 Bardswell Road 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2X No White Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Guilford Pharmacutical Chemical Technician s 1 and 2 should be filed v f Health and Mental Hygie Item 27 is marked other other traumatic avent, it other pelij 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Rosella Hampsey Francis Germida 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a :: If Item 27 is or other tra 929 Bardswell Road; Catonsville, Maryland 21228 Cecilia Germida Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/7/2006 injury o 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Catonsville, Maryland 22 Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licens any it 1630 Edmondson Avenue; Catonsville MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sub duna Physician /Medical Due to (or as a consequence of): Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to r as a consequence of) Examine rsicien and e burial-transit The law requires that the death certificate be executed IN ICAL EXAMINER Due to (or as a consequence of) Box 68760. Physician/Medical CERTIFICATION APPOOVE phys the £ attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Be Completed by End Stage Liver Disease 1 Yes 2 No 3 Probably 4 Nhknown should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has irector, page 2 s autopsy perforn 2 No 1 ☐ Yes 2 ☐ No 1 Yes Hospital or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Senpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes -254 ဥ After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 5 Pending investigation T E Natural 1 ☐ Yes 2 No Subject fell death. 3:50 p.<sup>M</sup> 01/19/2006 within 24 hours after death To the Funeral Director: , completely filled in by the f 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Highway reststop I - 95 <u>near</u> St. Augustine 29a. Certifie 18 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Li Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 5, 2006 00055 05 30. Name and address of person who completed dure of death (Item 23a) (Type, Print) Wolfe St 600

Registrar

State

31. Date filed (Month, Day, Year)

2006

32. Registrar's Signature

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene on o

	1	For State Registrar	State of Maryla		tificate of			eg. No.	JUb	11115
Physician /Medical		Decedent's Name (First, Middle, Last)  CLA PEN CE		6 E	エモ		Month 04	06	200 C	3. Time of Death
Examiner	4	a. Facility Name (If not institution, give s Johns Hopkins Ban		lonke	4b. City, Town, o	MoR4	h		It Mac	e Citu
Funeral Director	5	. Social Security Number 6. Sex		s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	9. Birthp	lace (State or Fereigr try) MD.
Maryland a-f show	1	Jsual Residence of Decedent  Oa. State 10b. County  MD. N/A	10c. (	City, Town or Lo	cation ALTIMORE				1	0d. Inside City Limils 1 AYes 2 □ No
h with the 13e or 28 st be not	1	0e. Street and Number  1000 N. IRIS AVE.			10f. Zip Code	21205	1	0g. Citizen	of Whal Coun	try?
permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.  To Be Completed by Funeral Director	1	1. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 □Yes 2 □ No If Yes, Give Year or Dates:	-	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☐ No	lispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)		Race - Americ Black, White, ecify: WI	
in 72 ho "natur sedical		15. Decedent's Educ (Specify only highest grade	completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	rking	16b. Kind o	of Business/Ind	dustry
ygiene.		Elementary/Secondary (0-12) 8TH	College (1-4or 5+)	P	IPE FITTI		(5)		ROWS PO	DINT
should be fill and Mental H marked ott amatic even	מ מ	17. Father's Name (First, Middle, Last) CHARLES GETZ					me (First, Middle, I WIEGMAN		name)	
and 2 shored alth and h		19a. Informant's Name/Relationship <i>(Typ</i> CATHERINE GETZ/WI					ural Route Numbel ALTIMORE,			
Pages 1 and of He int: If Item	2	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Ro 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		sition (Name of matory or other plac LL CEMET)				on - City or To MORE, I	wn, State MARYLAND
permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If item 27 is marked othn any injury or other traumatic event page.		21. Signature of Funeral Service License	96				HARLES S. , BALTIMO			
Physician /Medical Examiner		23a. Part1. Enter the disease, or complications of complete shock, pr heart failure. List only on the complete shock of the condition of the condition resulting in death)	cations that caused the decaused on each line.  Over Company of the control of th	equence of):	er the mode of dying Differ to	ng, such as cardia	c or respiratory arr	est,		Approximate Interval Between Onset and Death
titicate be executed by physicien and as the burial-transit	BY	Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):	VINCICA	_	1113			
	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1								•	
uires that a signed by lid be deta	<u>,</u>	Part II. Other significant conditions con	tributing to death but not r	resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	V		ne cause of death? ably 4 Unknown
Physician: The law requires that the death certhic certificate has been signed by the ettending director, page 2 should be detached for use To Be Completed by Physician/A							24a. Was a autops perform	n 24 sy med? 2 \( \text{No} \)	4b. Were auto prior to cor death? 1 □ Yes	psy findings available appletion of cause of 2 No
ysician: The is certificate director, pag	2	25. Was case referred to medical examiner?  1 □ Yes 2 No	ospital: 1 X npatient 2	☐ ER/Outpatier	nt 3 DOA Ot	0.0	ath (Check only or Home 5 ☐ Resid		Other (Specific	v)
Hing After Tune		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injur		28d. Describe h			,
		3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - Albuilding, etc. (Spe	t home, farm, str ocify)	eet, factory, office		28l. Location (S City or Tow		umber or Rura	l Route Number,
To the Hospitel or within 24 hours effer To the Funerel Dir completely filled in Medical Cert		29a. Certifier 1 Certifying Physical (Check only one) 1 Medical Examination (Check only one)	sician: To the best of my liner: On the basis of exam and manner stated.	knowledge, deat ination and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occ	e, and due to the c urred at the time, c	ause(s) and ate and pla	d manner as si ce, and due to	ated. the cause(s)
To th To th comp		29b. Signature and title of certifier_	MP		29c. Licens	398	2	9d. Date si	gned (Month, 06 06	Day, Year)
12	- 1	30. Name and odress of person who co	mpleted cause of death (I	tem 23a) (Type,	Print)	. Madical	Centra C491	OEAS)	CON Dec.	Bultimore,
10	_	31. Date filed (Month, Day, Year)	32. Sigistrar's Sig	- > 10 a . 100	sile)	WHENTER	Cina / C.		017 1407	SIBOR

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 = For State Registrar	Co	ertificate of Death	Reg	2006       6
	Physici	an	Decedent's Name (First, Middle, Las	()	lover	2. Date of Death Month	Day Year 3. Time of Death
	/Medic		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Dea	the property	4c. County of Death
	Examin	er	112 - 11	1.	Baltimore		NA
	Funeral	-	5. Social Security Number 6. S		y) If Under 1 Year If Under 24 Hr.	8. Date of Birth	9. Birthplace (State or Foreign
	Director		082-44-3022 1	□ M 25 Yrs.	Months Days Hours Min	8. Date of Birth (Month, Day, Ye 12-31-19	50 New York
	D .		Usual Residence of Decedent	40.00			,
	urytar show	_	10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits 12 Yes 2 □ No
	Ba-f	cto	100	ITO Dart	more		
	it is	Die	10e. Street and Number	1	10f. Zip Code	10g.	Citizen of What Country?
	ath v	Funeral Director	4202 Maine	AVA	21207	C	U.J.A.
	er de Item	nue	11. Marital Status		<ol> <li>Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue</li> </ol>	to Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs aft	by F	1/ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 → No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Black
5-0036	72 hours after death with the Maryland natural; or Items 23a or 28a-f show Iteal Exatration in the Inditive at	ed	15. Decedent's Ed	ucation 16a. Dec	cedent's Usual Occupation	16b	b. Kind of Business/Industry
215	n "na	plet	(Specify only highest gra	de completed) (Gir	ve kind of work done during most of wo . DO NOT use retired)	orking	\
212	d within giene. r then "	E	12	College (1-401 5+)	ouse Leeper		Domestic
	othe vent,	Se C	17. Father's Name (First, Middle, Last)			me (First, Middle) Maid	den Sumame)
<u>a</u>	should be filed within and Mental Hygiene. s marked other than " iumatic event, the Me.	To Be Completed	Joseph Joh	nson	Dorot	hy Pla	nty
Maryland	and h	. 55	19a. Informan's Name/Relationship (	ype, Print) 19b. Ma	uling Address (Street and Number or F	-0 .1	ty or Town, State, Zip Code)
	and 2 saith n 27	Ш	Ajesha Burte	y daughter 421	of Curtis Ave		nd. 21226
ore	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If it item 27 is marked other than 'natural', or items 23a or 28a-f show or other traumatic event, the Madical Exertains must be indiffied at		20a. Method of Disposition 1 → Burial 2 → Cremation 3 →	/ cometent c	position (Name of rematory or other place)	Date 20c	: Location - City or Town, State
Ē	Pag ment ant: t		4 Donation 5 Other (Specify		Cem 14-	14-2006 D	alls. led.
Baltimore	permit. Page Department o Important: tf any injury or once.		21. Signature of Funeral/Service Licen	500	2. Name and Address of Facilion	glass Fun	eral Service P.A.
	80 E = 0		Caulton C.	Wongan	1701 McCulloh	St. Ralto.	ND. 21217
В			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Do not e one cause on each line.	enter the mode of dying, such as cardia 1	ac or respiratory arrest,	Approximate Interval Between Onset and Death
1	Physician	ĺ	Immediate Cause (Final disease or condition	a Conderes	orator ta	luce	Origor and Octain
	/Medical Examiner	3	resulting in death)	Due to (or as a consequence of):			
*.	7.3%	_	Sequentially list conditions,	b. Due to (fr as a consequence of):	M		
\T	led sit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	A J A CONSEQUENCE OF			
٧.	rtificate be executed ng physicien and s as the buriat-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence of):	<i>,</i>		
09289	be e sicien buris		l l				
687	ficate physis the	Medical		d			
	certii nding use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	_		23d. Date of delivery
Вох	death certificate be e attending physicie d for use as the bur	Physician/	in the past 12 months?	4☐Pregnant at time of death	3 □Ectopic pregnancy 5 □ Other (s <i>pecify</i> )		Month Day Year
0	that the ded by the detacher	hys	9 □ Unknown	9□ Unknown			
o.	res that the de signed by the a be detached f	by P	Part II. Other significant conditions of	ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?
rd	- " 73	ed t				1 🗌 Yes	25No 3 Probably 4 Unknown
2	> 0 5	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
R	9 2 9	E				performed	i?   death?
ital	ician: Th certificate rector, pag	Be C	25. Was case referred to medical		26. Place of De	eath (Check only one)	
f V	Physician: this certific ral director,	70 E	examiner? 1 Tes ZENo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	ient 3 ☐ DOA Cther: 4 ☐ Nursing	Home 5 Residence	e 6 ☐ Other (Specify)
0	ding Pt The After the		27. Manner of Death SNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time	of 28c. Injury at	28d. Describe how in	
<u>io</u>	ttending death. ctor: After y the funer	atle	2 Accident investigation		M 1 ☐ Yes 2 ☐ No		
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree. City or Town, S	t and Number or Rural Route Number, tate)
Ω	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fu	Ce					
	Hosp 14 hou Fune tely fi	edical	29a. Certifier  (Check only one)  1 Certifying Ph 2 Medical Exer	ysician: To the best of my knowledge, de niner: On the basis of examination and/or	eath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the caus curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	thin 2 the mplet	Med	29b. Signature and title of certifier	and manner stated.	29c. <u>L</u> icense number	29d.	Date signed (Month, Day, Year)
	7 × 7 8		AIM	ALL VOL	D1/27/	7 4	100
	. 1		30 Name and address obnerson who	completed cause of death (Item 23a) (Tyc	pe Print)		1,0,00

State Registrar 31. Date filed (Month, Day, Year)
APR 1 1 2006

			For State	State of	f Marylan			of Health			ene	6		- 7
			Registrar  1. Decedent's Name (First, Middle, Last	·)						2. Date of Death		V	3. Time o	of Death
	Physicia /Medic		MARY ROSA GUA	RINO						APRIL	<sup>Day</sup> 4 200	)6	6:5	5p M
	Examin		4a. Facility Name (If not institution, give		nber)			own, or Location	of Death		4c. County	f Death		
			CLARE COURT CO					rimore	e O.A. Uso			0.001		
	Funeral		5. Social Security Number 6. Se 214-14-1384	X ☐M 2 <b>]X</b> (F	7. Age (In yrs 85	last birthday) Yrs.	If Under 1 Months	Days Hours	Min.	B. Date of Birth $(Month, Day, 1)$	(ear)	Cour	olace (State otry) YLANI	
	Director		Usual Residence of Decedent		0.5					74/14/1	. 920	PIZIN	IDANI	
	ylanc how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	Od. Inside C	•
	sa-fs	cto	MD		BA	ALTIMO	DRE						1 X Yes	s 2 🗌 No
	or 2	Director	10e. Street and Number				10f. Zip (			10	g. Citizen of W	hat Cour	itry?	
	eath y	erai	3725 ELLERSLIE		dent Ever in U.	S 13 L		1218 ent of Hispanic O	rigin? (Spec	ify Yes or No-	USA 14. Race	- Americ	an Indian.	
9	be filed within 72 hours after death with the Maryland the Hygiene. A the Hygiene of other then "natural", or items 23s or 28s-f show do other then "natural", or items event, the Madical Examiner must be notified at	/ Funerai	1 Never Married 2 Married	Armed For 1 ☐ Yes If Yes, Giv	rces? 2 <b>X</b> No	1	fYes, specif	fy Cuban, Mexica	in, Puerto H	ican, etc.)		, White,	etc.	
3	urel',	d by	3 Widowed 4 Divorced	Year or Da	ates:					4				
ς Δ	"nat	jete	15. Decedent's Edi (Specify only highest grad	le completed)		(Give	ient's Usual kind of work DO NOT use	Occupation done during mo retired)	st of working	g 11	6b. Kind of Bu	siness/in	Justry	
25	withi	Completed	Elementary/Secondary (0-12)	College (1 4YRS	-4or 5+)	TEAC					EDUCA	TIO	N	
פ	be fited within 72 tal Hygiene. d other then "natevent, the Medici	0	17. Father's Name (First, Middle, Last)					18. Moth	er's Name	(First, Middle, Ma	aiden Sumame	9)		
yar	should be nd Mental marked o matic eve	To B	MARION A. GUAR	INO						A F. PU				
Maryland 21215-0036	d 2 sh d and th and 7 is m traum		19a. Informant's Name/Relationship (7) SISTER JODENE	ype, Print)			•	Street and Numb ERSLIE						
ē,	Heal Heal tem 2		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name	e of	Da		Oc. Location -			
Ē	Pages ent of nt: If I		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			emetery, cren ST HOI		DEEMER	04/	10/06 E	BALTO.	CI	ry,MI	).
Baltimore,	permit. Pages 1 and 2 should by Department of Heath and Menta Important: If Item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service Licen-	<b>16</b> 0				Address of Facil	ENKIN	S & S0	NS CO			
	VO = 40		Willes Ca	ust	augad the deat		1692	<u>4 YORK</u>	RD M	<u>ONKTON</u>	MD.	2111	1 .	ato
н			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	ne cause on e	ach line.								Onset and	etween d Death
	Physician /Medical		disease or condition resulting in death)		or as a conseq		ecns	of the	MIL	re ines)	75/18		55	cers
	Examiner			Due to (	or as a conseq	dence or).								
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a conseq	uence of):		F 7 7 7						
9	and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
8760,	ate be executed hysicien and the burial-transit	al E	Toolaning in ababity East	Due to (	or as a conseq	uence or):								
	the the	edical		d										
ŏ	leath certific attending p	M.	IF FEMALE: 23b. Was decedent pregnant		come of pregna		7r				23d. Date	of delive	эгу	
P.O. Box	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 KINo		irth 2 ☐ Feta ant at time of d own		Ectopic pre Other (spe				Mor	th	Day	Year
P.O	that the de led by the a detached f	Phy	9 Unknown  Part II. Other significant conditions co			ulting in the u	nderlying ca	use given in Part	1	23e. Did toba	acco use contr	bute to t	ne cause of	death?
Division of Vital Records,	w requires that been signed to should be det	d by		anni Batang ta at		g		300 g.vo a.v		1			oably 4	
Š	s beer	Completed	A Company							24a. Was an		/ere auto	psy findings	s available
æ	Physician: The lav r this certificate has ral director, page 2 :	шo								autopsy perform	ed? d	eath?	mpletion of 2 <b>⊠</b> No	cause or
<u>a</u>	ian: artifica ctor, p	BeC	25. Was case referred to medical examiner?						e of Death	(Check only one				
>	Physician: r this certifica ral director, a	၉	1 ☐ Yes 2 No			ER/Outpatien				e 5 Resider			y)	
ב	ilng P	Certification:	27. Manner of Death 1 Natural 5 ☐ Pending		of Injury th, Day Year)	28b. Time of Injury	M 28	3c. Injury at Work? 1 ∐ Yes 2 □		8d. Describe hov	v injury occurre	∍d		
įsi	Attence death cetor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e, Place	of Injury - At h	ome, farm, str				8f. Location (Stre		or or Rura	I Route Nu	mber,
<u>&gt;</u>	al or / s after if Dire	Serti	4  Homicide determined	buildi	ng, etc. <i>(Specif</i>	(y)				City or Town,	State)			
	To the Hospital or Attending Ph within Z4 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier  (Check only  2 Medical Exam	inar: On the ba	asis of examina									(s)
	thin 2 thin 2 the	Medical	one) 29b. Signature and title of certifier	and man	ner stated.			License number		29	d. Date signed	(Month,	Day, Year)	
)	F 3 F 8		10/1-	At	feeding	my	)	1370	16		Avril		2006	
	2		30. Name and address of person who d		se of death (Item	п 23а) (Турө,	Print)	/						
	U		KENNETH GREENEN				LES	ST. SU	TE41	05 TOW	SON,MI	). 2	1204	•
	Sta Registi		31. Date filed (Month, Day, Year) <b>APR 1 1 2</b> 01		egistrar's Signa		all d							

ORIGINAL

		1 For State	State of M	laryland	•	rtment o			Mental		201	16	vivien.
		Registrar  1. Decedent's Name (First, Middle,	Last)		061	incate	OI Dec	2011	2. Date of	Reg. I	40 U		3. Time of Death
Physi	cian		Gill						Apri		Day 20	Year 006	8:30 p M
/Med		Dorothy R.  4a. Facility Name (If not institution,		)		4b. City, To	wn. or Loca	ition of Dea			4c. County		0.30 р
Exam	iner	743 Otterdale N				_	neyto				Carı		
Funera				ge (In yrs. la	ast birthday)	If Under 1 Y	ear If U	nder 24 Hi	rs. 8. Date o	of Birth		9. Birth	place (State or Foreign
Directo		214-18-2536	1□M 2\\ F	84	Yrs.	Months D	ays Ho	urs Mi	n. (Monti	4,19	21	Coui	MD
P .		Usual Residence of Decedent		1									
anylar	_	10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits 1 ☐ Yes 2 X No
8a-f	120	MD Carr	roll		Tane	ytown_							
ith th	Funeral Director	10e. Street and Number				10f. Zip Co				10g. (	Citizen of V	What Cou	ntry?
ath v	<u>a</u>	743 Otterdale N					21787				USA		
er de	n e	11. Marital Status	12. Was Decedent Armed Forces	?	S.   13. \	Nas Deceden f Yes, specify	t of Hispani Cuban, Me	ic Origin? exican, Pu	(Specify Yes of erto Rican, etc	or No- )		e - Ameno ck, White,	can Indian, etc.
S aft rs aft	by F	1 ☐ Never Married 2 ☐ Marrie 3 🖫 Widowed 4 ☐ Divorced	d 1 □Yes 2 ② If Yes, Give Year or Dates:			1 ☐ Yes 2 🔀	No Sp	ecity:			Specify		•
21215-0036  d within 72 hours after death with the Maryland glene. er then "natural", or Items 23a or 28a-f ahow . Ite Modical Examiner must be notilized at	g	15. Decedent's			16a. Deced	dent's Usual C	ccupation			16b.	Kind of Bu		<u>ite</u>
15 m	Completed	(Specify only highest	grade completed)	5.)	(Give	kind of work o	tone durina	most of w	vorking				,
The start	E	Elementary/Secondary (0-12)	College (1-4or	5+)	Но	usewif	e				Own I	lome	
ethys	BeC	17. Father's Name (First, Middle, L.	ast)				18. 1	Mother's N	lame (First, Mi	ddle, Maid	en Suman	10)	
Alenta be the tice of the tice	To B	Noah Bull						Maude	e Willa	rd			
Maryland nd 2 should be flie lith and Mental Hy 27 is marked oth	1	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	g Address (S	treet and N	lumber or i	Rural Route N	umber, Cit	y or Town,	State, Zip	Code)
and 2 realth 27 I		Darlene Harman	Daughte	r	743	Otter	dale :	Mill	Road,	Taney	town	, MD	21787
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show any niury or other traumatic event, the Modical Expanition manter man be notified as		20a. Method of Disposition  1 XBurial 2 Cremation	3 Demoual from State		ace of Dispo	sition (Name natory or othe	of r place)		Date	20c.	Location -	City or To	own, State
Page nent must:		4 Donation 5 Other (Sp.		1	rgreen	Mem.	Garde	ns 4	4/12/06	F	inkst	our,	MD
Balt permit. Departr Import	3	21. Signature of Fuperal Service L	icensee	1/	22	. Name and A	Address of F	Facility	118	24 Re	ister	stow	n Road
<b>a</b> 82 5 5 8	3	Seplo	- m for	Mu	5 E	line F	unera	1 Hom	ne Rei	sters	town,	, MD	21136
		23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that cause	d the death	. Do not ent	er the mode o	f dying, suc	ch as cardi	iac or respirate	ory arrest,			Approximate Interval Between
Physicia	1	Immediate Cause (Final disease or condition		m	NO CAR	NAL	Fr	PARC	من م				Onset and Death
/Medica		resulting in death)	Due to (or as	s a consequ	ence of):								
Examine		Sequentially list conditions.	b	C	0000	my f	teter	N	Dreas	<u>_</u>			10
V D =	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as	s a consequ	ence of):								
and trans	am	Cause (Disease or injury that initiated events resulting in death) Last	c									_	
8760, <a href="https://doi.org/10.10/2/2016/">dx</a> At the property of the principle of	<u> </u>	resuming in additify East	Due to (or as	s a consequ	ence of):								
876 cate to cate to cate to cate to	dical		d										
on of Vital Records, P.O. Box 68 ding Physician: The law requires that the death certifica h. After this certificate hes been signed by the attending ph funeral director, page 2 should be detached for use as if	by Physician/Med	IF FEMALE:	23c. If yes, outcome	e of pregnar	acv.								
Box eath cert attendin	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal	death 3	Ectopic pregr						te of deliv inth	ery Day Year
P.O.	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	at tiltie of de	aun 5	Other (speci	(y)			_			
that t	된	Part II. Other significant condition	ns contributing to death	but not resu	Iting in the u	nderlying caus	se given in l	Part I.	23e.	Did tobacc	o use cont	ribute to t	he cause of death?
ds, uires ti signe d be c			relevo vasu		DIXZ					1 Tes	2 🗆 No	3 Prot	bably 4 Unknown
v requ	Completed								242	Was an	24h	Wore auto	opsy findings available
Ae lav	臣								-	autopsy performed	1 1	prior to co	impletion of cause of
Vital Record reiclan: The law requir s certificete hes been si		as Manager and a section							1 🗆 Y		No .	1 🗌 Yes	2□ No
Vit sicla certi	Be C	25. Was case referred to medical examiner?  1 Yes You No	Hospital: 1 ☐ Inpat	: 0 O I	ER/Outpatier	a□ D04	Other		eath (Check o		a 🗆 🗆	(0	
Of Phy or this	15	27. Manner of Death	28a. Date of Inj (Month, D		28b. Time of		Injury at Work?	□ Nursing	Home 5 28d. Desc	ribe how in			y)
On Sding	흗	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga		ay Year)	Injury	М	Work? 1 ☐ Yes	2 🗌 No					
Division If or Attending efter death. Director: After din by the fune	Hica	3 Suicide 6 Could no	ned 286. Place of Ir	njury - At hor	me, farm, str	eet, factory, o	ffice					er or Rura	al Route Number,
Direction of the price of the p	Certification:	4 Homicide	building, e	etc. (Specify	)				City o	r Town, St	a <i>te)</i>		
Division  To the Hospital or Attence within 24 hours efter death To the Funeral Director: completely filled in by the	aic	29a. Certifier 1 Dertifying	Physician: To the bes	t of my knov	vledge, deatl	n occurred at t	the time, da	ate and pla	ice, and due to	the cause	(s) and ma	anner as s	stated.
the Ho nin 24 the Fu	edicai	one)	xeminer: On the basis and manner s	tated.	ion and/or in	vestigation, in	my opinion	i, death oc	curred at the t	ime, date a	and place,	and due t	o the cause(s)
To the To the To the Comp	Σ	29b. Signature and title of certifier	_ /./			29c. L	icense num		_	29d. l	Date signe	d (Month,	Day, Year)
			100 t	ATC '	<u> </u>		DO	1364	3		4	- 10-	06
8		30. Name and address of person w						1 40	nas b	- 7	ANE	uta	n mo
Ü		2 43		trar's Signat		7.0							24387
	tate	31. Date filed (Month, Day, Year)											

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Ragistrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 2. **Physician** 2006 oher /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard County Howard County General Hospital Columbia If Under 1 Year II Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 🕅 M 2 🗆 F Yrs. 561-44-9276 72 18, 1934 Director Panama Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a State 10c. City, Town or Location item 27 is marked other then "neturel", or items 23a or 28s-f show other traumatic event, the Madical Examinar must be notified at 1 Yes 2 No Directo Maryland Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death v
Department of Heelth and Mental Hygiana.
Important: If item 27 is marked other then "neturel", or iteme 23a any injury or other traumatic event, the Medical Examiner muser page. 10701 Vista Road 21044 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 No 1955− If Yes, Give Year or Dates: 1976 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Soldier U.S. Air Force 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Henry Holland Dorothy Marie Sjoberg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10701 Vista Road, Columbia, MD 21044 Kathleen Ann Holland/wife 20b. Place of Disposition (Name of cemetery. Crematory of other place)
MD Veterans Cemetery April 10,
Crownsville 2006 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State MD 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD Donaldson Funeral Home & Crematory P.A. 1411 Annapolis kd., Odenton, MD 21113 21. Signature of Funeral Service Licensee M01427 meluco Umodeo Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Immediate Cause (Final **Physician** years resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Donknown Completed relive 24a. Was an autopsy performe 24b. Were autopsy lindings available prior to completion of cause of death?
1 ☐ Yes 2☐ No 1 ☐ Yes 2 1 No : After this certifice funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient ٩ 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification; 1 Anatural 5 Pending 1 Yes 2 No 2 Accident investigation Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a Conflying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and little of sertifier 29c. License number OB 541 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Little Patuxent DALVATERRA 32. Registrar's Signature 31. Date liled (Month, Day, Year) State 2006 Registrar

			1 - For State Registrar	State of M	laryland / D	epartme Certific			l Mental H	ygiene Reg. No	2006	A continue A	120
	Physic		1. Decedent's Name (First, Middle, Last) Lee David Hoshall, J	^.					2. Date of I	Death Day	Year 200 L	3. Time of 3:10	Death M
	/Medi Examir		4a. Facility Name (If not institution, give s	l at Be	ltim-re	1	30141	r Location of De	F	4c.	County of Death		
	Funeral Director		220 00 0022	M 2□F	ge (In yrs. last birtl	frs. If Un Mont	hs Days	If Under 24 H Hours M		Birth Day, Year) DEY 12,	9. Birth	olace (State on the control of the c	or Foreign
	the Maryland 28a-f show	or	Usual Residence of Decedent  10a. State 10b. County  Maryland N/A		10c. City, Town							10d. Inside C	ity Limits
	or 28a-	Director	10e. Street and Number				Zip Code 21214			10g. Citi	zen of What Cou	ntry?	
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23e or 28e-f show many injury or other traumatic event, the Medical Examination must be notified at sone.	by Funerai	11. Marital Sfatus  1 X Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Armed Forces 1 [X] Yes 2 [ If Yes, Give Year or Dates:	? No				(Specify Yes or lento Rican, etc.)	No-	14. Race - Ameri Black, White, Specify: Whit	etc.	
25	Baltimore, Maryland 21215-0036 semit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene.  Miportant: if item 27 is marked other then "natural", or may injury or other traumatic event, the Mudical Expression.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementery/Secondary (0-12)  College (1-4or 5+) 5+  Lawyer  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Lawyer  Lawyer							nd of Business/Ir	dustry		
7	land 2	To Be C	17. Father's Name (First, Middle, Last) Lee David Hoshall, Sr.						ou Shippey		Sumame)		
Hospall	and 2 shouself and Mary		19a, Informant's Name/Relationship (Type Clarence W. Hill/Compa	nion	4500	Mailing Addr O Elsroc	ess (Street de Aven	<sub>and Number or</sub> ue Balti	Rural Route Nun more Mary	land 2	r Town, State, Zij 21214	Code)	
<del></del>	More, Pages 1 a nent of Hei int: if item		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State Entonbment	Green M	y, crematory ount Cer	or other plac neterv	4/1	Date 5/06		cation - City or T		
	Balti permit. Departn imports eny inju		21. Signature of Funeral Service License	Christin Hutte	a L. Hilton	n 22. Name Leonar 5305	and Address d J. R Harford	ss of Facility UCK, Inc. Road Ba	ltimore M	aryland	1 21214		
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulfing in death)	e cause on each Pru	d the death. Do n	not enter the r			iac or respiratory	arrest,		Approximate Interval Bet Onset and 2 do	tween
	8760, cate be executed the burial-transit control of the burial	dical Examiner	Sequentially list conditions, in any, beauty to in reclassic cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Olive to (or s	s a consequence o	.():						19 7	; :w}
	Division of Vital Records, P.O. Box 68 to attending Physician: The law requires that the death certifica effer death.  Director: After this certificate has been signed by the ettending ph in by the funeral director, page 2 should be detached for use as it in by the funeral director, page 2 should be detached for use as it.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2 ☐ Fetal death at time of death	3 ⊟Ectopi 5 ⊟ Other	c pregnancy (specify)	1		-	23d. Date of deliv Month	•	Year
	rds, P	2	Part II. Other significant conditions con	tributing to death	but not resulting in	the underlying	ng cause giv	en in Part I.			ise contribute fo	he cause of o	
	I Record The law requirete has been sl page 2 should I	Completed					· ·		pe	as an topsy formed?	24b. Were autoprior to condeafh?		available cause of
	Vital Fisions: The certificate rector, page	Be	25. Was case referred to medical examiner?	ospital:	-5500		Oth	er	Death Check onl	2 2 -			
	Sion of Vital Retained by Sicion of Vital Present the Seath.  The funeral director, page	ition: To	1 Yes 2 WNo  27. Manne Death 1 Vatural 5 Pending 2 Accident investigation	28a. Dafe of Inj (Month, D			28c. Injur Wor	4 🗀 Nursin	g Home 5 ∐ Re 28d. Describ		6 □Other (Speci y occurred	<i>fy)</i>	
	<b>≒</b> 5 € 5 ≤	Certification:	3 Suicide 6 Could not be determined	28e. Place of Ir building, e	njury - At home, far atc. (Specify)	rm, street, fac	ctory, office			(Street an Fown, State	d Number or Rui )	al Route Num	n <i>ber</i> ,
	Divi	edicai (	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examir	sician: To the bes ner: On the basis and manner s	of examination and	, death occur d/or investiga	red at the tir tion, in my o	ne, date and pla pinion, death o	ace, and due to the courred at the time	ne cause(s) e, date and	and manner as a d place, and due	stated. to the cause(s	s)
	To the vithing vithing to the comp	M	29b. Signature and time of certifier	Sty M	<b>D</b>		29c. Licens	1	98		te signed (Month,	Day, Year)	
	10		30. Name and address of person who co	mpleted cause of	death (Item 23a) (	Type, Print)	المكاس	aLR	.98 Ulimori	,			
	St. Regist	ate rar	31. Date filed (Month, Day, Vear)  APR 1 1 200	A STATE OF THE STA	trat's Signature	doses	e de la	7 12	11111111				

		_	For State Registrar	State of Ma	aryland / I	Departmer Certifica				Reg. h	~ UUO	1 2
>	Physicia /Medic Examin	al .	1. Decedent's Name (First, Middle Marilyn  4a. Facility Name (If not institution Social Security Number	M. Hoerr m, give street and number)	tal cer	iter	-	Location of D	Death	ril o	Post Sear Sear Sear Sear Sear Sear Sear Sear	3. Time of Death 4:05-A M h MOSE hplace (State or Foreign
	Funeral Director		240-64-5153  Usual Residence of Decedent  10a. State 10b. County	1 □ M 2 □ <b>X</b> F	6 4	Yrs. Months	Days	Hours	Ju	ite of Birth onth, Day, Yes ne 1,	1941 Nor	th Carolin
	he Maryi 28a-f sho cullied a	ector		timore		Middle	Riv	er		100.6	Citizen of What Co	1 Yes 2 No
	3a or		12922 Easter	rn Ave.			21220	)		US		with y .
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "neturel; or Items 23a or 28a-f show strip injury or other traumatic event, I'm Medical Examinar must be notified at an once.	by Funeral Director	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced	If Yes Give		13. Was Deci If Yes, sp		spanic Origin n, Mexican, F Specify:	n? (Specify Y Puerto Rican,	es or No- etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
Maryland 21215-0036	within 72 ho lene. 'than "netur I'e Medical I	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12) 12th	nt's Education est grade completed)  College (1-4or 5	5+)	Decedent's Use (Give kind of we life. DO NOT	ork done d use retired,	ution u <i>ring most</i> o	f working		Kind of Business estaura	
yland 2	ould be filed Mental Hyg arked other atic event,	To Be C	17. Father's Name (First, Middle, Ted Miller	Last)					Name (First Huge	S Middle, Maid	en Sumame)	
Mar	d 2 sho th and th and 7 is m traum		19a. Informant's Name/Relations Robert Hoer:			o. Mailing Addres					y or Town, State, 2 ce MD	Zip Code)
Baltimore,	Pages 1 an nent of Heal ant: if Item 2 ury or other		20a. Method of Disposition  1X Burial 2 Cremation  4 Donation 5 Other (S		20b. Place of camera HOII	of Disposition (Na ory, crematory or Y Hill	ame of other place Ceme	etery	Date 4/10	/06 B	Location · City or altimor	
Balt	permit. Departimport. eny inj		21. Signature of Funeral Service	Licensee Onn	elly	22. Name a					ve. Bal	
ÿ	Physician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	a. Card	ne.	scula		such as ca	ardiac or resp	iratory arrest,		Approximate Interval Between Onset and Death
8760,	eath certificate be executed attending physician and for use as the burial-transit	dical Examiner	Securi tially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	с	a consequence							
P.O. Box 68	Physician: The law requires that the death certifica t this certificate has been signed by the attending ph ral director, page 2 should be detached for use as it	by Physician/Med	1F FEMALE: 23b. Was decedent prognant in the past 12 months? 1 □ Yes 2 W No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal deat	n 3 ☐Ectopic 5 ☐ Other (s					23d. Date of de Month	ivery Day Year
rds, P.	quires that t n signed by uld be deta		Part II. Other significant conditi	ions contributing to death b	out not resulting	in the underlying	cause give	en in Part I.	2	3e. Did tobacc		o the cause of death?
Vital Records,	ysician: The law require is certificate has been si director, page 2 should b	Completed	·						-	4a. Was an autopsy performed □ Yes 2 V	prior to death?	utopsy findings available completion of cause of
<u> </u>	sician certifi irector	o Be	25. Was case referred to medical examiner?  1 Yes 2 70	Hospital:	ent 2□ER/O	utpatient 3□ D	Othe		f Death (Che		6 ☐Other (Spe	m.6.1
Division of	Sing After		27. Manner of Death	28a. Date of Inju	ıry 28b.	Time of Injury	28c. Injury Work		28d. D	escribe how in		City)
Divis	To the Hospital or Attentwithin 24 hours after death To the Funeral Director:	Certification:	3 Suicide 6 Could 4 Homicide determ	minor 289. Place of In	jury - At home, f c. <i>(Specify)</i>	arm, street, facto	ry, office			ocation (Street ity or Town, St		ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in I	edical	29a. Certifier 1 Certifyi (Check only one) 2 Medical	ing Physician: To the best Il Examiner: On the basis of and manner st	f examination a	e, death occurre nd/or investigation	d at the timen, in my or	ne, date and pinion, death	place, and du occurred at t	ue to the cause the time, date	e(s) and manner a and place, and due	s stated. e to the cause(s)
	To the To the Comple	Me	29b. Signature and title of certifie		u.ou.	2	9c. License	number		29d.	Date signed (Mont	h, Day, Year)
	/		) Source	M			Re	5001	DO	C	4.09	5-06
	Sta Registi		30. Name and address of person  Sommer  31. Date filed (Month, Day, Year	Abdel-Me	death (Item 23a)	(Type, Print)	nhli	n Sg.	vare (	rive, f	baltimer	E,100 21337

DHMH 17 Rev 1/2001

Hoerr, Marilyn

	•	•	State of Maryland / D	epartment of Health and No Certificate of Death	Mental Hygie	_	11122
Physic	an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
/Medi		John Marshall Hartl				2006	7:00 A. M
Examir	ner	4a. Facility Name (If not institution, give str 1841 East Edgewater		4b. City, Town, or Location of Death  EdgeWood	1	4c. County of Death Harford	County
- Julia		5. Social Security Number 6. Sex	7. Age (In yrs. last birti	nday) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth		place (State or Foreign
Funeral Director		195-26-1766  Usual Residence of Decedent		rs. Months Days Hours Min.	8. Date of Birth (Month, Day, ) Sept. 02,	1933 Fred	erick Co.VA
within /2 nours atter death with the Maryland sne. sne. "tetural", or iteme 23e or 28e-f ehow ne Medical Exacinar mant be notified at	tor	10a. State 10b. County Maryland Harford	l County Edgev				10d. Inside City Limits 1 ☐ Yes 2 🛱 No
Multivie Sa or 28a I be noti	Director	10e. Street and Number 1841 East Edgewater	Road	10f. Zip Code 21040	100	g. Citizen of What Cou United St	•
Tie 2.	Funeral		2. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Ameri	can Indian,
al', or ite	by Fur	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puert  1 ☐ Yes 2 ☐ No Specify:	o Hican, etc.)	Black, White	ite
jians. r than "naturai", or iteme 23s or 28s-f show the Medical Espointer maal be notified at	Completed	15. Decedent's Educa (Specify only highest grade	ation 16a. College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	king	6b. Kind of Business/Ir	ndustry
r than	E	Elementary/Secondary (0-12)	N/A	Unemployed		Unemploy	red
d other	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Nan	ne (First, Middle, Ma	aiden Surname)	
20	ToB	Henry Clinton Hartl	.ey	Bessie M	May White		
h and 7 is m traum	6 (8	19a. Informant's Name/Relationship (Type Ms. Sharon Devenny (		Mailing Address (Street and Number or Ru 11 Edgewater Road	iral Route Number, ( Edgewood ,		o Code) 21040
f Healt item 2 other		20a. Method of Disposition		Disposition (Name of v, crematory or other place)		oc. Location - City or T	
0 == =		1 ☐ Burial 24 Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	Funeral Chapel	8 06	Forest Hil	l,Maryland
Department Important: any injury once.		21. Signature of Funeral Service Licensee	J. gan or	22. Name and Address of Facility Peaceful Alternati - 2325 York Road T	yes Funer 'imonium,	al&Cremati Maryland	on Ctr.,P.A 21093
nysician Medical xaminer priial-transit	ner	23a. Part / Entir the disease, or complications, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury)	V		, or respiratory arres	4,	Approximate Interval Between Onset and Death
physician and s the burial-transit	lical Examiner	Cause (Disease or injury that initiated events resulting in death) Last c.	Due to (or as a consequence o	f):			
by the attending parached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	very Day Year
gned be de	þ	Part II. Other significant conditions control	ributing to death but not resulting in			cco use contribute to	
page 2 should I	Completed				24a. Whas an autopsy pertormo	prior to c	opsy findings available ompletion of cause of
certificate rector, pag	Be (	25. Was case referred to medical examiner?		26. Place of Dea	ath (Check only one	)	
h. After this ce funeral dire	ဥ	1 Pos 2 No Ho  27. Manner of Death 1 Natural 5 Pending	spital: 1 Inpatient 2 ER/Out  28a. Date of Injury (Month, Day Year)  28b. T		lome 5 Residen	ce 6 Other (Spec	ify)
within 24 hours after death.  To the Funeraf Director: After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Stre	eet and Number or Rui	ral Route Number,
ours afte neraf Dir filled in		,		, death occurred at the time, date and place			stated.
he Fui pletely	Medical	(Check only 2 Medical Examinations)	ar: On the basis of examination and and manner stated.	for investigation, in my opinion, death occu	irred at the time, dat	e and place, and due	to the cause(s)
To the Complet	Σ	29b. Signature and title of certifier	4-2	29c. License number	29	d. Date signed (Month	, Day, Year)
		· conjainsour	WAD	D16619	/	4 prex 7, 2	006
		30. Name and a ss of person who com  C VERGARA - SOR	npleted cause of death (Item 23a) ( RPES 9940 F/S	29c. License number  DIGGI 9  Type, Print)  PANKUN SQUAPE II	PR- BA	CTIMORE A	10.21236
St Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 1 20	32. Registrar's Signature	Sporte			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarAmend Item #10c,d,e&f Per FH Certificate of Ocath 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Year 2157 2006 APril Carmen Anni Hrynko /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Hospital Bel Air Harford Social Security Number 7. Age (In yrs. last birthday) II Under 24 Hrs. 8. Date of Birth 09-06-1962 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 ☐ M 2 🕱 F Hours Germany 43 212-94-1012 Director Yrs Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Maryland Harford Director Whiteford XX Yes 27No Bel Air 10f. Zip Code 10g. Citizen of What Country? 2 should be filed within 72 hours after death with to and Mental Hygiene.

Is marked other then "natural", or Items 23a or 2 333 Kenmore Ave, Apt. 5 U.S.A. 4549 Flintville 21014 Completed by Funeral Road <del>21162</del> 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White 3 Widowed 4X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Friendlys 12th Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be . Pages 1 and 2 should be timent of Health and Menta tant: If item 27 to marked Unknown Runate Kanstein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Runate Knight/Mother 4549 Flintville Rd., Whiteford, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If its any injury or o 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith Maus, 04-12-06 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Miller-Dippel Funeral Home, Inc. m 6415 Belair Road, Baltimore, MD 21206 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List part one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** STreptococca /Medical Due to (or as a consequence of): Examiner Streptococca Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that with the cause of the Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown sate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Failure, Renal 3 Probably 4 □Unknown oagulo pathy 24a. Was an 24b. Were autopsy lindings available prior to completion of cause of death?
1 ☐ Yes 2 No autopsy performed? Yes 2 No Hrynko, Carmer this certificate 1 Yes : After this certification, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation within 24 hours after death.

To the Furieral Director: A completely filled in by the fu 1 Yes 2 No 6 Could not be 3 ☐ Suicide 28e. Place ol Injury - At home, farm, street, factory, office building, etc. (Specify) 281 Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the bast of my knowledge, death conumed at the time, date and plane, and due to the dause(s) and which an stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number laru completed cause of death (Item 23a) (Type, Print) Mar Lo Lamora, SUD Upper Carsopears Vive

DHMH 17 Rev 1/2001

State Registrar

31. Date liled (Month, Day, Year)

2006

N80025841

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23a,25,27,28a-f per MF, G854,04/10/06dhb Certificate of Death Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 458 pm **Physician** LARENCE 66 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BAYVIEW Care Center Himon Baltimore C If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-12-1922 6. Sex 1 M 2 ☐ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 83 212-18-2943 Yrs **Director** Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location Show 10a. State treumatic event, the Medical Exactiner must be notified at MD Baltimore City Baltimore 1X Yes 2 □ No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23e or 6622 O'Donnell Street 21224 death v 12. Was Decedent Ever in U.S. Amed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: hore, Maryland 21215-0036 white 2 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Carpentry 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( and Mental I Marv Haverkamp Bertha Clarence Jacob Hohman Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6622 O'Donnell Street, Baltimore, MD 21224 If item 27 l Mr. Michael Hohman/son other 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Loudon Park Cemetery 3/7/2006 Department o Important: If any injury or once. ò Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Singleton Funeral Home P.A. 21. Signature of Nuneral Service Licensee 1 Second Ave SW<sub>Glen</sub> Burnie MD 21061 M01364 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic obstrye /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner FRTIFICATION APPROVED BY MEDICAL TYMANIES Due to (or as a consequence of): Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. , Hypertension 1 No 3 Probably 4 Unknown nodules 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an ame autopsy hip Frotvre 2710 Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nersing Home 5 Residence 6 Other (Specify) Certification; To 1 ₹ Yes <del>2</del> E of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death O2/26/2006 Found: 6p.m. vision or Attending 5 Pending investigation Fall after death. 2. Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

The control of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, State)

Johns Hopkins Bayview Care Ctr

505 Hopkins Bayview Circle

1 Gertifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

All of the cause(s) and manner stated. 3 Suicide in by 4 Homicide Hospitel 24 hours a 29a. Certifier Medical To the I within 2 To the I 29c. License number 29b. Signature and title of certifier 3-3-2006 D333/6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hykin Boyyew Circle Bolfinson MO 21224

Registrar DHMH 17 Rev 1/2001

State

PR 1 0 2006

5505

M.D

32. Registrar's Signature

Registrar

State 31. Date filed (Month, Day, Year) APR 1 1 2006

32. Registrar's Signature Alasma &

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

			1- State of Ma Registrar Amend Item #11 Per	aryland / Depa FH C85/ <b>G9</b> /1				ene 0 0	6 11126	
i	Physici		Decedent's Name (First, Middle, Last)     SHIRLEY		MMER		2. Date of Death APRIL 6	D	Year 3. Time of Death 1:05 P M	
	/Medic Examir		4a. Facility Name (If not institution, give street and number) HOSPICE OF BALTIMORE GILCHE	RIST CTR.		Location of Death TOWSON		4c. County of Death BALTIMORE		
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M F 7. Age  103-22-9317 6. Sex 1 M 2 M F 7. Age  Usual Residence of Decedent	e (In yrs. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth AUG • 22 • 1	929	Birth place (State or Foreign Country)     NY	
	death with the Maryland ms 23a or 28a-f show	Director	10a. State 10b. County MD BALTIMORE  10e. Street and Number	10c. City, Town or Loc BALT	IMORE  10f. Zip Code		100	, Citizen of W	10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
36	or its	by Funeral DI	33 STONEHENGE CIRCLE #6  11. Marital Status  1 □ Never Married 2 Married  XXWidowed 4 □ Divorced  12. Was Decedent to Armed Forces?  1 □ Yes 2 M of the Status of Page of Pag	No	Vas Decedent of H Yes, specify Cuba	21208 ispanic Origin? (Spe in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		USA - American Indian, , White, etc. WHITE	
21215-0036	within 72 iene.	Completed t	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5)	(Give k		ation during most of worki ) GEMENT SP	ng		GOVERNMENT	
Maryland 2	be filed that Hyg d othe event,	To Be C	17. Father's Name (First, Middle, Last)  ABRAHAM	RUBINS		18. Mother's Name SADIE			LIEBMAN	
	5 5 5 E		19a. Informant's Name/Relationship (Type, Print)  ANN HOLSTEIN / DAUGHTER  20a. Method of Disposition	2004	JOLLY RO	AD - BALT	IMORE, M	21209		
Baltimore,	it. Pages riment of riant: If i		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Fulleral Service Licensee	ARLINGTON	atory or other plac	MUNO 4/9/	2006 B	ALTIMOR		
Ba	permi Depa Impo eny li		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lir	8	900 REIS	TERSTOWN	ROAD - P	IKESVIL	LE, MD 21208 Approximate	
68760,	Physician and // Medical Examiner as the private intensit	edical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  a. Due to (or as to be cause).	1	Cance				Interval Between Onset and Death Grant'S	
P.O. Box (	ettendin for use	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown  23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3 1	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day Year	
	w requires that the deben signed by the should be detached	ρ	Part II. Other significant conditions contributing to death by			en in Part I.			oute to the cause of death?  B Probably 4 Unknown	
al Reco	The law ete hes b page 2 st	e Completed					24a. Was an autopsy performe 1 ☐ Yes 2 €	pr d? de	ere autopsy findings available ior to completion of cause of iath? Yes 2 No	
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: Atter this certific completely filled in by the funeral director.	Certification; To Be	25. Was case referred to medical examiner?  1  Yes	28b. Time of Injury	28c. Injun Worl M 1	y at ⟨? Yes 2 □ No	me 5 🗌 Residena 28d. Describe how	injury occurre		
	the Hospite in 24 hours the Funera pletely filla	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of Medical Examiner: On the basis of and manner sta	f examination and/or invested.	estigation, in my o	oinion, death occurre	ed at the time, date	e and place, ar	nd due to the cause(s)	
	To the I within 2 within 2 To the I complete	2	29b. Signature and title of certifier  M. Hong hile  30. Name and address of person who leted caus of the control of the contr	7 c CVD eath (Item 23a) (TVDA F	29c. Licenso	2,502_	129c	Date signed	(Month, Day, Year)	
	Sta Registr		31. Date filed (Month, Day, Year)  32. Agistra  APR 1 1 2006	6701 N- ar's Signature	Charles	St. Ba	Sto, M	15 1	20%	

Director    262-30-4233   1	7:37 A <sup>M</sup>
Marking   Mark	ath  eorge's  inthplace (State or Foreign Country)
14110 Adkins Road   14110 Adkins Road   14110 Adkins Road   15. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   18 Under 14 Part   18 Under 24 Pris.   8. Date of Birm (Month, Day, Year)   9. Bit (Month, Day, Year)   102 Cell (Month, Day, Year)   102 Cell (Month, Day, Year)   103 Cell (Month, Day, Year)   104 Cell (Month, Day, Year)   105 Cell (Month, Day, Year)   106 Cell (Month, Day, Year)   106 Cell (Month, Day, Year)   106 Cell (Month, Day, Year)   107 Cell (Month, Day, Year)   108 Cell (Month, Day, Year)   108 Cell (Month, Day, Year)   108 Cell (Month, Day, Year)   108 Cell (Month, Day, Year)   108 Cell (Month, Day, Year)   108 Cell (Month, Day, Year)   108 Cell (Month, Day, Year)   108 Cell (Month, Day, Year)   108 Cell (Month, Day, Year)   108 Cell (Month, Day, Year)   108 Cell (Month, Day, Year)   108 Cell (Month, Day, Year)   108 Cell (Month, Day, Year)   108 Cell (Month, Day, Year)   108 Cell (Month, Day, Year)   108 Cell (Month, Day, Year)   108 Cell (Month, Day, Year)   109 Cell	eorge's irthplace (State or Foreign Country)
S. Social Security Number  262-30-4233  1	irthplace (State or Foreign Country)
Director    262-30-4233   1	
10a. State   10b. County   10c. City, Town or Location   Laurel   10d. Zip Code   10g. Citizen of What County   10e. Street and Number   10d. Zip Code   10g. Citizen of What County   10e. Street and Number   10d. Zip Code   10g. Citizen of What County   10e. Street and Number   10d. Zip Code   10g. Citizen of What County   10e. Street and Number   10d. Zip Code   10g. Citizen of What County   10e. Street and Number   10d. Zip Code   10g. Citizen of What County   10e. Street and Number   10d. Zip Code   10d. Zip Code   10g. Citizen of What County   10d. Zip Code   10	or rad
Specify only highest grade completed   College (1-4or 5+)   College (1-4or 5+)   Department of the control of	10d. Inside City Limits
Specify only highest grade completed   College (1-4or 5+)   College (1-4or 5+)   Department of the control of	1 ☐ Yes ¾XNo
Specify only highest grade completed   College (1-4or 5+)   College (1-4or 5+)   Department of the control of	Country?
Specify only highest grade completed   College (1-4or 5+)   College (1-4or 5+)   Department of the control of	
Specify only highest grade completed   College (1-4or 5+)   College (1-4or 5+)   Department of the control of	
Specify only highest grade completed   College (1-4or 5+)   College (1-4or 5+)   Department of the control of	
Elementary/Secondary (0-12) 12th 4 Business Administrator State Gov 18. Mother's Name (First, Middle, Last) William Henry Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, William M. Johnson/Son 3450 N. Hualapai Way, #1087 Las Vegas, William M. Johnson/Son 20a. Method of Disposition 1 Burial 2 Ceremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Physician Medical Examiner    Physician   Medical   Examiner   Sequentially list conditions   Atrial Fibrillation   Atrial Fibrillation	s/Industry
18. Mother's Name (First, Middle, Maiden Sumame)   19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, with the first of Number or Rural Route Number, City or Town, State, with the first of Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rural Route Number or Rura	windustry
18. Mother's Name (First, Middle, Maiden Surname)   19. Mailing Address (Street and Number or Rural Route Number, City or Town, State.   19. Mother's Name (First, Middle, Maiden Surname)   19. Mother's Name (First, Middle, M	vernment
Mattle Pate	
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral House of Green tell, and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  20b. Place of Disposition (Name of cemetery, crematory or other place) West Arundel Crem. 4/9/2006 Odenton, Molino 313 Talbott Avenue, Laurel, MD 2070  221. Signature of Funeral Service Licensee 222. Name and Address of Facility Donaldson Funeral House of Green tallure. List only one cause on each line.  223a. Part : Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  225b. Place of Disposition (Name of cemetery, crematory or other place) West Arundel Crem. 4/9/2006 Odenton, Molino 313 Talbott Avenue, Laurel, MD 2070  226c. Location - City or cemetery, crematory or other place) West Arundel Crem. 4/9/2006 Odenton, Molino 313 Talbott Avenue, Laurel, MD 2070  226c. Location - City or cemetery, crematory or other place) West Arundel Crem. 4/9/2006 Odenton, Molino 313 Talbott Avenue, Laurel, MD 2070  227. Name and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Addres	
20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral House of Green tell, and the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  Physician (Medical Examiner)  20b. Place of Disposition (Name of cemetery, crematory or other place) West Arundel Crem. 4/9/2006 Odenton, Molino 313 Talbott Avenue, Laurel, MD 2070  221. Signature of Funeral Service Licensee 222. Name and Address of Facility Donaldson Funeral House of Green tallure. List only one cause on each line.  223a. Part : Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  225b. Place of Disposition (Name of cemetery, crematory or other place) West Arundel Crem. 4/9/2006 Odenton, Molino 313 Talbott Avenue, Laurel, MD 2070  226c. Location - City or cemetery, crematory or other place) West Arundel Crem. 4/9/2006 Odenton, Molino 313 Talbott Avenue, Laurel, MD 2070  226c. Location - City or cemetery, crematory or other place) West Arundel Crem. 4/9/2006 Odenton, Molino 313 Talbott Avenue, Laurel, MD 2070  227. Name and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Address of Facility Donaldson Funeral House and Addres	
West Arundel Crem. 4/9/2006 Odenton, Moline Signature of Funeral Service Licensee  22. Name and Address of Facility Donaldson Funeral Homeway Molines  Moline Signature of Funeral Service Licensee  22. Name and Address of Facility Donaldson Funeral Homeway Molines  23. Part 1. Fiter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, so or heart failure. List only one cause on each line.  Physician Medical Examiner  Physician Medical Examiner  Sequentially list conditions  Atrial Fibrillation	
23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only the cause on each line.  Physician /Medical disease or condition resulting in death)  Sequentially list conditions  Atrial Fibrillation	MD
23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only the cause on each line.  Physician /Medical disease or condition resulting in death)  Sequentially list conditions  Atrial Fibrillation	
Physician /Medical Examiner  Immediate cause (Final disease or condition resulting in death)  a. Stroke Due to (or as a consequence of): Atrial Fibrillation	07
disease or condition resulting in death)    Atrial Fibrillation	Approximate Interval Between
Examiner  Sequentially list conditions  Due to (or as a consequence of):  Atrial Fibrillation	Onset and Death  1 day
Sequentially list conditions D.	CALL STORY
if any, leading to immediate Due to (or as a consequence of):	10 yrs
if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Hypertension  Due to (or as a consequence of):	10 years
Tesulting in death) Last  Due to (or as a consequence of):	
Cause, Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
O SE SE SE SE SE SE SE SE SE SE SE SE SE	
FFEMALE:   23b. Was decedent pregnant   1	elivery Day Year
1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the conditions of the conditions are contributed to the conditions.	
	to the cause of death?
Type 2 Diabetes  1 Yes 2 No 3 P	robably 4 □Unknown
Type 2 Diabetes  1 Yes 2 No 3 P  24a. Was an autopsy performed?  performed?	autopsy findings available completion of cause of
25. Was case referred to medical examiner?	
1 Inpatient 2 EH/Outpatient 3 DOA Wirsing Home 5 X Residence 6 Other (Sp.	ecify)
28d. Describe how injury occurred  28d. Date of Injury  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred	
28d. Describe how injury occurred  28d. Describe how injury occurred	Rural Route Number,
City or Town, State)	
29a. Certifier (Check only one)  1	
1	as stated. le to the cause(s)
D43237 April 6,	ue to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	nth, Day, Year)
Paul Armstrong, MD 14201 Laurel Park Drive, #102, Laurel, MD 207	nth, Day, Year)
State Registrar APR 1 2006 32 Registrar's Signature	nth, Day, Year)

06-02363	
Johnson,	Noble

Please Type or Print in Black Indelible Ink

hnson, Noble	1	St · For State	ate of Marylan		rtment of tificate of		Mental H	ygiene	201	16 11	121
Physician		<b>Registrar</b> 1. Decedent's Name (First, Middl	le,Last)	001	imouto or	Dodin		2. Date of Deat	eg, No. ·- ·	3. Time of Dea	ath
edical Examin	-	Noble G. Joh	nson					Month April 6, 20	Day Year	6:40	
*		4a. Facility Name (if not institution  Johns Hopkins Hospit	on, give street and numb	er)	4	b. City, Town, or L Baltimore	ocation of Death		4c. County of	n/a	
Funeral Director		5. Social Security Number		Age (In yrs. Ia	st birthday)	If Under 1 Year Months Days	If Under 24Hrs Hours Min	8. Date of Bir	th (MM/DD/YYYY)	9. Birthplace (State o Country)	r Foreigi
Birector	١,	220-94-3040 Usual Residence of Decedent	1X M 2 F	2	6 Yrs.			11/19	7/1979	Maryland	b
v any		10a. State 10b. County		10c. City,	Town or Location	on				10d. Inside Cit	*
Maryland 28a-f show d at once.	ğ	MD	n/a		Balti	More 10f. Zip Code				1 Yes 2	! No
ne Mary or 28a	Director	10e. Street and Number  5633 Alhambi	ma Arraniia					10	0g. Citizen of Wha	t Country?	
	<u>.</u>	11 Marital Status	12. Was Decederarried Armed Force			21212 Decedent of Hispans, specify Cuban,			USA - 14. Race - White,	American Indian, Blacetc.	ck,
after d	<u></u>	• •	1 Yes  vorced If Yes, Give Year or Dates:	Z KI NO	1	Yes 2 No	specify:		Specify:	African	āan
hours	leted r	15. Decedent's Education (Spe	cify only highest grade		16a, Decedent during	s Usual Occupation	on (Give kind of v	vork done	16b. Kind of Busi		
215-0036 be filed within 72 ntal Hygiene rked other than " ent, the Medical i	i biei	Elementary/Secondary (0-12)  11th	College (1-4	or 5+)	most of w	orking life. DO NO	T use retired)		Restua	arant Sto Clerk	ock
215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica	Compi	17. Father's Name (First, Middle,	, Last)		Labo		8.Mother's Name	(First, Middle, M	Maiden Surname)	CIELK	
Me Me	0 26	Noble Johns 19a. Informant's Name/Relations		Step-	19b. Mailing		Rochell and Number or F		hber, City or Town,	State, Zip Code)	
ore, MD s 1 and 2 sho of Health and If item 27 is ner traumati	- 2	William P. H 20a. Method of Disposition 1 X Burial 2 Cremation		20b. P		ion (Name of ceme		oss Ct.		MD 2120 City or Town, State	)7
altimore, mit. Pages I a partment of He portant: If ite		4 Donation 5 Other St	pecify:		ng Mem	. PArk	4/1	2/06	Woodla	awn, MD Balto. (	
Baltimo permit. Pag Department Important: injury or of		21. Signature of Funeral Service	///////	/_	22. Na	O Tibes	of Facility Wy 1	ie F/H	I PA of	Balto. (	30.
Physician	1	23a Part I, Enter the disease, or failure. List only one cause	complications that eus	sed the death.	Do not enter th	e mode of dying, s	uch as cardiac o	, Kand r respiratory arre	BALLS COV est, shock, or hear	yn, MD 21	Interval
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	B. A Ikimila Come							Between On Death	
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a co	nsequence of	):						
J n is		(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	nsequence of	):						
xecuted		LINDENDED	d AMENDED	19a ne	r fh g8	54 4-11-	06 vt				
60, ate be e hysiciar e burial	Jedic	UNPENDED  F FEMALE:	23c. If yes, out						23d Date of d	eliveny	
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transi	Physician/Medical	3b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnan	n t at time of dea	2 Fet	al death 3 er (Specify)	Ectopic pregna	nncy	Month	•	ear
the dea	֟֝֟֝֟֟֝֟֝֟֟֟	Part II. Other significant condit	9 Onknown		sulting in the u	nderlying cause giv	ven in Part I	23e Did to	bacco use contrib	ute to the cause of dea	ath?
P.O.	2					,, 3		1 Yes			known
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director. After this certificate has been seled in by the funeral director, page 2 should death.	Completed							24a. Was a		ere autopsy findings a or to completion of cal	
Reco The law cate has	E O							perfor	med? de	ath?  ✓ Yes 2	No
	n Pe	25. Was case referred to medical examiner?				T .	of Death (Check	only one)			
F Vit Physic er this	0	1 ✓ Yes 2 No 27. Manner of Death			ER/Outpatient					Other:	
nding th. r: Afte	ion '	1 Natural 5 Pend	28a. Date of (Month Date) Apr 6, 200	gy,Year) O	28b. Time of In 6:07		es 2 V No	Deceased S	now injury occurred Shot	J	
/iSic r Atte ter dea irrecto	ICa Ea		stigation 28e. Place o	f Injury - At ho	me, farm, stree	, factory, office but	ilding, etc.			or Rural Route Numb	
Division of Vital   Hospital or Attending Physician: 43 hours after death. Pureral Director: After this certifiely filled in by the funeral director.	Certification: 1	4 Homicide deter		ocal Stree	t			500 Block S	<sup>tate)</sup> heridan Aven	ue, Baltimore, M	D
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	<del>ر</del> ة (	1	hysician: To the best o miner: On the basis of e	examination ar							
To Tio	ğ :	29b. Signature and title of certifie	and manner state	11		29c. License	number		29d. Date signed	(Month, Day, Year)	
		1/	HM/	V(		O.C.M	1.E.		April 7, 2006	j	
	;	30. Name and address of person				Chro-t D-Ir	mara MD 01	201			
\ Stat		Susan Hogan MD.  31. Date filed (Month, Day, Year)	Assistant Medical	trar's Signatur		n Street, Baltir	nore, MD 21	201			
Registra	-	APR 1		SAR J	& So	refer					
DHMH 17 Rev 1/200	1	erib d			ORIGINAL	_					

DHMH 17 Rev 1/2001 OCME 10/2003

			1 - For State Registrar	State o	of Marylar		artment rtificate			and M	-	giene Reg. No. U	06	1113	10
775	Physici	an	Decedent's Name (First, Middle, L Ruth		able		Jones	2			2. Date of De. Month	Day	Year	3. Time of D	
*	/Medic Examir		4a. Facility Name (If not institution, g Manor Care N.H.	ive street and nu			4b. City,		Location o	f Death	4		06 ounty of Deat NA	8:07p	
	Funeral Director		5. Social Security Number 6. 231–38–4285 Usual Residence of Decedent	Sex 1 □ M 2 <b>X</b> F	7. Age (In yrs. 70	last birthday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Da 2-8-3	h y, Year) 6	9. Birti Co	hplace (State or buntry) Va.	Foreign
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City	Limits
	Ba-fel	ctor	Md. N	A		Balti	more							¶∑ Yes	2 🗌 No
	vith th	Dire	10e. Street and Number				10f. Zip					_	n of What Co	ountry?	
	eath ne 234	erai	3015 Wylie Ave.	12. Was Dec	edent Ever in U	I.S.   13 '	Was Dared	212		nin? (Spe	cify Yes or No		USA Race - Ame	rican Indian	
21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or fleme 23a or 28a-f ehow event, the Medical Examirar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Fo	orces? 2∭XNo ve	i	If Yes, spec		Specify:	, Puerto I	cify Yes or No Rican, etc.)	1	Black, White		
5-0	72 hc	Completed	15. Decedent's (Specify only highest g	Education trade completed)		(Give	dent's Usua kind of wor	k done d	urina most	of worki	ng	16b. Kind	of Business/	Industry	
121	within ane. than '	idm	Elementary/Secondary (0-12)	College (	1-4or 5+)		no not us mploy						NA		
d 2	lifed Hygi ther nt, 1		12th grade  17. Father's Name (First, Middle, Lat	st)		Offic	мртоу		18. Mothe	r's Name	(First, Middle,	Maiden Su			
/lan	should be ind Mental I	To Be	Moses	I	Covelace	€			Po]	llye			Petty		
Maryland	1 and 2 Health a am 27 li		19a. Informant's Name/Relationship Odaris Tyner	(Турө, Print) Sist	er		_				Balti		own, State, 2 212		
Baltimore,			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	□Removal from		Place of Dispo cemetery, crei	sition (Nam natory or of	ne of ther place	9)	D	ate	20c. Loca	tion - City or	Town, State	
Ë	Pag tment tant: i		4 ☐ Donation 5 ☐ Other (Spec	cify)		arriso					-06	Owin	gs Mil	ls, Md.	
Bal	permit. Pages Department of h Important: if ite any injury or of														
#			shock, or heart failure. List on	mplications that ly one cause on	each line.			e of dying	~			rrest,		Approximate Interval Betw Onset and Dr	een
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	myel	s dy s	plas	re	D(.	Cus	der				
. H	Examiner			Due to	Or as a consec	quence of):		·	d	100	der veler				
1	P ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	(or as a consec	циелсе of):	gerv								
V	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	Ren	al	Fa	Min	le_						
8760,	ate be executed sysicien and he burial-transit		Toolang in South, East	Due to	(or as a consec	(Rence or):	-0	De	chm	¢.					
687	ficate p phys s the	edical		d		8-574			o m						
Вох	Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown			Ectopic pregnancy Other (specify)					23d. Date of delivery Month Day Year				
, P.O	thet the by a detail	by Ph	Part II. Other significant conditions					ause give	n in Part I.		23e. Did t	obacco use	contribute to	the cause of de	ath?
rds	w requires been sign should be		Degenen	ture	Joint	Dife	are				101	fes 2□	No 3□Pr	obably 4 🖰 🖯	nknown
Vital Records,	law re as be	Completed									24a. Was		24b. Were au	utopsy findings as completion of car	vailable use of
<u>~</u>	: The law cate has l	Co									perfo 1 ☐ Yes	rmed?	death? 1 ☐ Yes		
Vita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe	- /	,	(Check only o				
o	ig Phye ter this neral di	. To	1 Yes 2 No  27. Manner of Death	10	Inpatient 2 of Injury oth, Day Year)	ER/Outpatier 28b. Time o		Bc. Injury Work	NU		ne 5 Residence 1			cify)	
ion	를 중 등 를	ation	1 □ Matural 5 □ Pending 2 □ Accident investigati		ith, Day Year)	Injury	М		? ′es 2 □ l	No					
Division	efter des Director of in by th	Certification:	3 Suicide 6 Could not 4 Homicide determine	289. Place	e of Injury - At h ing, etc. (Speci	ome, farm, str	eet, factory	, office		4	28f. Location (S City or Tox		Number or Ru	ural Route Numb	er,
	To the Hospitel or Attending within 24 hours effer death. To the Funerei Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying I (Check only one) 1 Medical Ex	Physician: To the aminer: On the b	e best of my kno easis of examina oner stated.	owledge, deat ation and/or in	h occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the ed at the time,	cause(s) ar date and pl	nd manner as ace, and due	stated. to the cause(s)	
	To the To the Comp	ž	29b. Signature and title of certifier	- 2	N	10		License					-	h, Day, Year)	
				1~		(I)		リ	3141	64		4	11010	6	
	1		30. Name and address of person wh SHOALIS A. L+	o completed cau A-SI+MI	se of death (Ite	m 23a) (Type, 21 N	Print) EUT	410	CL 4:	inte	JO4,	13AC	7 (1810)	RE MD	2120
	Sta Regist	400	31. Date filed (Month, Day, Year) APR 1 1 20	06	Registrar's Sign	ature	W								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death APRIL. **Physician** 10. 2006 03:35 COTT JOHNSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Joseph Medical Center Saint Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F 214-72-699 Yrs Director MARYLAND Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or iteme 23s or 28s-f ehow the Medical Examiner must be notified at BALTIMORE 1 Yes 2 No Director ARKUI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21234 0909 NWOOD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: à 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ind of Business/Industry للزامة 72 12 should be filed within 7 h and Mental Hygiene.
7 is marked other then "r TRECISION Elementary/Secondary (0-12) College (1-4or 5+) ARPENTAR ONCRETE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARLENE KENNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Item 27 2904 AVE ARKUILLE SPOUSE JOHNSON LINWOOD MO 21234 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State Peges 1 ment of t Cametary, crematory or other place)
GARDENS OF
FAITH CEMETERY APRIL Department of Important: If it eny injury or o 1 Dourial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 13,2006 KOSSUICCE 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 8800 HARFORD RU. PARKVILLE EVANS FUNERAL MD 21234 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC NON-SMALL CELL LUNG CANCER MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.0. ed by the detached 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? (es 2 No 1 ☐ Yes 1 Yes

cete has been signification could be supposed to the could be supposed After this certificate has Attending Physicien: funeral director, Certification:

death.

the st

the Director:

filled in by within 24 hours after or To the Funerel Direct completely filled in by

Medicai

State Registrar

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

1 Natural
2 Accident

5 Pending investigation 6 Could not be determined

1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 Yes 2 No

26. Place of Death Check only one

TOWSON, MARYLAND

28f. Location (Street and Number or Rural Route Number, City or Town, State) 10 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29a. Certifier (Check only one) 29b. Signature and title of certified

3 🗀 Suicide

4 - Homicide

29c. License number D37254

29d. Date signed (Month, Day, Year)

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON P LIM. 31. Date filed (Month, Day, Year) 7601 OSLER DRIVE

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month **Physician** 00: 50AM Thelma Mae Johnson Apri 09 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Sount Agnes Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Jay Year July 15, 1929 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 M 2 XF 76 225-32-8009 Virginia Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene.
ant: If Item 27 le marked other then "natural", or Iteme 23a or 28a-f ehow ant: If Item 27 le marked other then "natural", or hother traumatic event, I're Medical Examinar must be notilliad at any or other traumatic event. I're Medical Examinar must be notilliad at 10a. State 10c. City, Town or Location 10d. Inside City Limits 27 ie marked other then "natural", or iteme 23a or 28a-1 ebov traumatic event, the Madical Examinar must be notified al 1 ☐ Yes 2 📉 No Director Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Shady Nook Avenue 21228 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Charlie F. Via Eva ٧. Garrison ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda A. Ramp, daughter 415 Shady Nook Avenue Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1
Depertment of H
Important: If Ite
ony injury or ot 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Metro Crematory, Inc. 04/10/06 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George MacNabb 21. Signature of Funeral Service Licensee Cremation Society of MD, Inc. 299 Frederick Road Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumu **Physician** wee disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consuguiance of Examiner Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 5 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) P.O. deteched 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 Ho 3 Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has The 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ۵ 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 2 □No death. 1 ☐ Yes investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide hours efter within 24 hours e 1 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only ane) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) randen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ca Daniel

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1

2006

1

2. Registrar's Signature

			For State Registrar	State of Ma	aryland / Dep	artment of F			iene 9. No. 0 0 6	- 33	
	q		Decedent's Name (First, Middle, La	st)				2. Date of Deat	h	3. Time of Death	
	Physici /Medio		Gladys Margaret	Jenkins				April 6	Day Ye 2006	6:30 AM M	
	Examin		4a. Fecility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of De		4c. County of E		
	P.		3822 Prospect Roa			Street	T 444		Harford		
	Funeral		5. Social Security Number 6. S	ex □ M 2□F XX	e (In yrs. last birthday)  Yrs.	If Under 1 Year Months Days	If Under 24 H	in. (Month, Day,		Birthplace (State or Foreign Country)	
	Director		237-30-7254 Usual Residence of Decedent	XX	80 Yrs.		12-11-1925 N.				
	yland		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits	
	B Mar	ctor	Maryland Harford		Street					1 ☐ Yes 21 No	
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23s or 28s-f show aumatic event, the Medical Examinar must be notified at	by Funeral Director	10e. Street and Number 3822 Prospect Road	đ		10f. Zip Code 21154		10	Og. Citizen of Wha	t Country?	
	eath 18 234	era	11. Marital Status	12. Was Decedent I	Ever in ILS 13		lispanic Origin?	(Specify Yes or No-		American Indian,	
(0	r Iten	臣	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ ★	1-	If Yes, specify Cuba	an, Mexican, Pu	erto Rican, etc.)		Vhite, etc.	
93	ral', o	d b	3 Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	<u> </u>	1 ☐ Yes Ž	Specify:		Specify:	White	
2	72 h	Completed	15. Decedent's E (Specify only highest gra	ducation (de completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of w	vorkina	16b. Kind of Busine		
2	within ane. than	ш	Elementary/Secondary (0-12)	College (1-4or 5	+)	r Owner	3)	1 -	Highland	Park	
9 9	filed Hygid Sther sent,	ပိ	17. Father's Name (First, Middle, Last		FOLINE	1 Owner	18. Mother's N	lame (First, Middle, M	Cemetery Maiden Sumame)		
Maryland 21215-0036	id be ental ked c	To Be	Christopher E. Car	rney			Etta M	lay Ormsby			
ary	and Man		19a. Informant's Name/Relationship (					Rural Route Number,		re, Zip Code)	
Σ	and 2 salth a n 27 l		Lorraine Vease1/Da	aughter			Road, S	treet, Man	cyland 2	1154	
altimore,	ges 1 t of He If item or oth	1	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State		matory or other place			20c. Location - City		
Ē	tment tent:		` 4 ☐ Donation 5 ☐ Other (Specif	y)		n Mem. Pa		-10-06 W	ilmingto	n, N.C.	
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic a <u>once</u> .		21. Signature of Euneral Service Licer	1588		2. Name and Addre	O	415 Belain		-	
			23a. Part1. Enter the disease argent shock, or heart failure. List only	plications that caused	the death. Do not en	Miller-Di ter the mode of dyin	ppel Fu	neral Home	e, Inc.	Approximate	
	Dhusfalan		shock, or heart failure. List only. Immediate Cause (Final	one cause on each lin	10. 1. 1. 1.				,	Interval Between Onset and Death	
į.	Physician /Medical		disease or condition resulting in death)	a. Due to (or as:	a consequence of):	Wheles	+ Ccc.	ncer		2915	
Н	Examiner				a 00.100q20.100 0.,.						
7	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Lind Underlying Cause (Disease or injury	Due to (or as	a consequence of):						
	ecuter and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						111	
760,	ate be executed hysician and the burial-transit	E E		Due to (or as	a consequence of);						
687	Attending Physician: The law requires that the death certificate be executed redeath. The death are death are certificate has been signed by the attending physician and ector: After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	dicai		d							
Box (	eath certific attending p	J/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. Date of	delivery	
ă	death e atte d for	icla	in the past 12 months? 1 □ Yes 2 ☑ No	1⊟Live birth 4⊟Pregnant at		⊒Ectopic pregnancy ⊒ Other <i>(specify)</i>	<u> </u>		Month	Day Year	
<u>Р</u> О	res that the death signed by the atter I be detached for u	Physiclan/Med	9 🗆 Unknown	9 Unknown							
S, F	gned be de	by P	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in the u	nderlying cause giv	en in Part I.			e to the cause of death?	
Records,	w require been sig should b	ted			4.00.00			1 🗆 Ye	s 2 □ No 3 □	Probably 4 Winknown	
ec	e law e has be ge 2 sh	Completed						24a. Was ar autops	24b. Were	autopsy findings available to completion of cause of	
E	ysician: The is certificate hadirector, page							perform	ed? death		
<u> </u>	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		t all post Oth	00	eath (Check only one			
ō	Phys r this ral di	To	1 ☐ Yes 2 ☒No  27. Manner of Death	1 L Inpatie		II JE DOA	4 LI NUISING	Home 5 Reside		Specify)	
O	ding F th. After tuner	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	Year) Injury	Wor	k? Yes 2 □ No		,,		
Division of Vital	Attending Ph or death. ector: After th by the funeral	ifice	3 Suicide 6 Could not b	e 28e. Place of Infu	rry - At home, farm, str	reet, factory, office		28f. Location (Str	eet and Number of	Rural Route Number,	
Ö	tal or s afte al Dir	Certification:	4 Tromicios	building, etc	. (Ѕреспу)			City or Town	, State)		
	To the Hospital or Attenwithin 24 hours after deating the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying Pt (Check only one)	niner: On the best of and manner sta	examination and/or in	h occurred at the tin vestigation, in my o	ne, date and pla pinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manne te and place, and	r as stated. due to the cause(s)	
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and mariner sta		29c. Licens			d. Date signed (M	onth, Day, Year)	
	- s - ō		Bus	`		D	548-6	+1	4/060	106e	
	10		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type,	Print)	LITER	ILAIR I			
_	10		DR. BAHRANI	602	S. ATWO	OD AU	5 -BE	LAIR	415		
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	d) =					
	Registr	i p	APR 1 1 2	006	of the						
DHI	MH 17 Rev 1/2	UUT		3							

ORIGINAL

Amend Items 23a, PtI, II, 25, 27, 28a-f per ME, 6854, 004/10/06dhb 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death February 5, **Physician** 2006 8:00 A M Anne O. Johnson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore 4501 Fullerton Avenue | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 9, 1 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🖸 F 84 Yrs. 215-12-4931 Director 1921 Maryland Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10a, State 10c. City. Town or Location 10b. County Item 27 is marked other then "neturel", or Items 23e or 28e-f show other treumetic event, the Madical Experience or unit by notified at Maryland Baltimore 1 ☐ Yes 2 X No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21236 U.S.A. 4501 Fullerton Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other then "neturel", or Itel 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: à 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Western Electric Secretary 12th Grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jeannie May Shoemaker Lawrence 0tt19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James G. Keffer (grandson) 312 Cannon Street, Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State ö permit. Page Department of Importent: If eny injury or Parkville, Maryland 2/9/2006 \* 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 21. Signature of the all Service Prisee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Belair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hypertensive Atherosclerotic Cardiovascular Approximate Interval Between Onset and Death **Physician** Cerebro Vancellau disease or condition resulting in death) /Medical Due to (or as a consequ Examiner Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner g physician and as the burial-transit CERTIFICATION APPROVED BY MEDICAL EXAMINER mil Due to (or as a consequence of): ician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) detached Physi 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Stroke, Tibia fracture 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has autopsy performed? 1 ☐ Yes 2 🗷 No To the Hospitel or Attending Physicien: the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1X Yes 25 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 01/30/2006 1 ☐ Yes 2 XNo efter death. Unknown M Fall 2X Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Baltimore, MD determined 4 \ Homicide 4501 Fullerton Ave. at home within 24 hours e 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2-06-06 pleted cause of death (Item 23a) (Type, Print) Dr. 30. Name and address of person who St. A 308 Eutai 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar APR 1 0 2006

			1 - For State Registrar	State of M	aryland /	-	artmen rtificate			and M	-	giene Reg. No.	006	* 1	1135
			1. Decedent's Name (First, Middle, La	st)							2. Date of De Month	ath Day	Yea	0.5	3. Time of Death
	Physici /Medio		Samuel J	. Kiro	chner							8, Ž0		ai	7:00 P M
}	Examin		4a. Facility Name (If not institution, giv	street and number	)		4b. City,	Town, or	Location o	f Death		4c. C	ounty of D	eath	
			6612 Ridge Road				R	osed	ale				Balt	imo	re
	Funeral		Social Security Number     6. S		ge (In yrs. last	birthday)	If Under Months	1 Year Days	If Under	24 Hrs Min.	8. Date of Bir (Month, Da	th V Year)	9. 1	Birthplac	ce (State or Foreign
	Director		190 10 3330	M 2 F	81	Yrs.	Wortens	Duys	riours		Feb 27		5 Pe		ylvania
	pu .		Usual Residence of Decedent  10a, State 10b, County		10c. City, T	oum or La	netice.							140-	4 Inside Circle inite
	aryla eho	-	Top. County		Toc. City, 1	OWIS OF LO	Kation							100	I. Inside City Limits  1 ☐ Yes 2X No
	N 9 €	ecto	Maryland Baltimor	e	Ros	edal									
	with t	Funeral Director	10e. Street and Number				10f. Zip					10g. Citize		Country	y?
	ath a	ral	6612 Ridge Road	1				237					SA		
	er de litem	nue	11. Marital Status	12. Was Decedent Armed Forces	?	13.	Was Deced If Yes, spec	ent of His	spanic Orig n, Mexican	gin? (Spe i, Puerto	ecify Yes or No Rican, etc.)	)-   14	l. Race - A Black, W		
36	If Yes, Give 10.43 A.C. 1 Yes 2 Decity: Specify:									n +	_				
5-0036	hou	ed	15. Decedent's Ed				dent's Usua	I Occupa	tion			16b King	of Busine	hite	
5	in 72 an" n	Completed	(Specify only highest gra	ide completed)		(Give	kind of wor	k done d	uring most	t of worki	ing	TOD: Paint	or Dagine	33/11/04	Stry
2	the second	l lio	Elementary/Secondary (0-12)	College (1-4or		neta	llati	າກ TN	achni	can		Fvv	on Co	,,,,,,,,,,	ration
D	Hygi ent,	Be C	17. Father's Name (First, Middle, Last)	1		.IID Ca.	TTACE	J11 1			(First, Middle,			TEOT	Lacion
<u>a</u>	ld be ental ked c	To B	Samuel E. Kirchne	r					Vic	la	Day				
Maryland 2121	s 1 and 2 should if Health and Men ttem 27 ie marke other treumatic	-	19a. Informant's Name/Relationship (	Type, Print)	1	19b. Mailir	ng Address	(Street a			I Route Numb	er, City or	Town, State	e, Zip C	ode)
	nd 2 lith a 27 ic		Mary Jane Kirchne	r (wife)		6612	Ridge	e Ro	ad Ro	seda	le Mary	yland	2123	7	
ā,	s 1 a of Hea item othe		20a. Method of Disposition		20b. Place	of Dispo	sition (Nan	e of	1		Date	20c. Loca	ation - City	or Town	n, State
Baltimore,		3	1 XBurial 2 ☐ Cremation 3 ☐ 4 Donation 5 ☐ Other (Specification)		' 1		11 Mei			4/1	2/06	Ralt:	imore	Col	inty, Md.
	permit. Page Depertment of Important: if eny injury or ance.		21. Signature of Funeral Service Licer	-	11022		. Name an								Home PA
ñ	Deperment of the police only is	li, J	14 12	0		1	107 O	ld E	aster		enue Es				
			23a. Part1. Enter the disease, or com	plications that cause	d the death. D									A	pproximate
	Physician		shock, or heart failure. List only Immediate Cause (Final	one cause on each i	ine.	211		1. 0		-	~~				nterval Between Onset and Death
1	Physician /Medical Examiner  Immediate Cause (Final disease & condition resulting in seath)  Due to (or as a consequence of):  Due to (or as a consequence of):  Sequentially list conditions,  Due to (or as a consequence of):										I Mucholi				
	Examiner				11	3	-	. صدر	> C	cale	omy oh a	16		5	10000)
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as	a conseque	Jof):	- Cris				10	1			georg
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events												-
<u> </u>	exec en an rial-tr	Exa	resulting in death) Last	Due to (or as	a consequen	ce of):		-							
8760	The law requires that the death certificate be executed tie has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical		d											
89	tifica ng ph as th	Med	IS SSIAN S												
Вох	eath certific attending p	Jan A	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			DEctopic pre	agnancy				23	d. Date of		
H	dea se att	SC	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant a 9☐Unknown			Other (sp						Month	Da	ay Year
0	that the de led by the a detached f	h,	9 Unknown								-				
- Ś	res tha signed be del	by	Part II. Dther significant conditions of	ontributing to death b	out not resultin	g in the u	nderlying ca	use give	n in Part I.		23e. Did t	obacco use	contribute	e to the	cause of death?
5	w require been sign	Pe	_ csvertos,	.)	2						10,	Yes 2□	No 3₽	Probab	oly 4 □Unknown
ပ္ထ	aw respectively	plei	Chronic	Brach	the						24a. Was		24b. Were	autops	y findings available
ž	hysicien: The law his certificate has b I director, page 2 s	Completed	Chris	inval	Laile	س					autor perfo	rmed?	death	1?	Detion of cause of ☐ No
<u> </u>	ien: rtifica stor, p	0	25. Was case referred to medical	- C	)				26. Place	of Death	(Check only g			-	
_	Physici this ce al direc	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpati	ent 2 ER/	Outpatien	it 3□ DO	A Othe	-		ne 5 Resid		☐Other (S	Specify)	
0	ding Ph h. After th funeral		27. Manoer of Death 1 □Natural 5 □ Pending	28a. Date of Inju (Month, Da	ury 28I	b. Time of Injury	2	3c. Injury Work	at 2		28d. Describe I	how injury	occurred		
<u> </u>	ath. ath. r: Af	atc	2 ☐ Accident investigation	1	, ,	,,	М		es 2 🗆 N	No					
Division of Vital Records,	or Attending Physicien: ifer death. Diector: Aller this certifice in by the funeral director, is	₽ E	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of in	jury · At home tc. (Specify)	, farm, str	eet, factory	office			28f. Location (: City or Tox		Number or	Rural F	Route Number,
Õ	ital o	Certification:			, , ,						, 2 0	, 2.2.0/			
	To the Hospital or Attendi within 24 hours efter death. to the Funeral Director: A completely filled in by the fu		29a Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best niner: On the basis o	of my knowled	dga, death	vestigation	tha the	e date and	d plane, t	and due to the	date and n	nd manner	as state	ed.
	the F nin 24 the F	Medical		and manner st	ated.										
	رة وقع	2	29b. Signature and title of certifier	11.	)		**	License		/		29d. Date	-	/	ıy, Year)
	γ		1 / hat of	Mereden			_   4	ועו	844	>		4/1	0/06	•	
K	+1		30. Name and address of person who							47.60	Name of the last	Lat entre and			
)	1 '		Martin J. Sheridar	M.D. 68	30 Hos	oital	Dr.S	uite	102	Ealt	imore,	Mary Mary	land	2123	37
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 1 20	06 Hegisti	rar's Signature	S. A. S. S. S. S. S. S. S. S. S. S. S. S. S.									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 04 Physician o7 2006 11:25 PM Eva Mary Augusta Kinder /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 209 Chorus Way Millersville Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 ☐ M 2 🖾 F 217-22-7861 89 Yrs. 10-22-1916 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show r 28e-f show 1 ☐ Yes 2 No Director VA Clarke Berryville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "naturel", or items 23a or the Medical Examiner must be 2955 Allen Road 22611 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 25 No Specify: white þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) .. Pages 1 and 2 should be fill timent of Health and Mental H tant: If Item 27 is marked ott jury or other traumatic even John Henry Foerster Eva Ditzel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Carolyn L. Merkle /daughter 209 Chorus Way; Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: if eny injury or once. 4 □ Donation 5 □ Other (Specify) Glen Haven Mem. Park | 4-11-2006 Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral Home, PA 21. Signature of Funeral Service\_Licenses Moi357 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CEREBRO VASCULAR ACCIDENTY **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Date to (or as a consequence of) Examiner physician and is the burial-transit Due to (or as a consequence of) Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of ause of death? 14700 THY KO1015171 24a. Was an autopsy performed 20 No 1 Yes 1 Yes 2 √No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 KOther (Specify) Residence Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) á 4 Homicide Provident: To the best of my knowledge, Seath perumed at the time, data and place, and due to the cause(s) and manner as stated 29a Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Box 68760, o ۵. Records. Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in

> State Registrar

tel Eren 31. Date filed (Month, Day, Year) APR 1 1 2006

29b. Signature and title of certifier



-2 MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Highway Paradena Mayland 21122

	•	For State Registrar		State of	of Mar	yland /	•			ealth a Death	and M	lental Hy	gien. Reg. No	UUC	1	demonstrated by the control of the c	37
Physicia		1. Decedent's Name (First, Middle	, Last)									2. Date of De Month	aath Da	ay Y	'ear	3. Time	
Physicia /Medica		Thomas Xavi	er l	Keefe	Jr.							April	4	200	_	3:42	2 Рм
Examine	er	4a. Facility Name (If not institution						4b. City	, Town, or	Location o	f Death		40	. County of	Death		
**************************************	\$- ·	7810 Clark F 5. Social Security Number	d. 6. Sex			In yrs. last b	irthda		essur r 1 Year		24 Hrs	8. Date of Bir		Howar		lana /Ctata	as Francisco
Funeral Director				M 2□F	59	iii yis. iasi b	Yrs.	Months		Hours	Min.	(Month, Da	ay, Year	)	Cour	ilace (State itry) W You	
100		220-54-5295 Usual Residence of Decedent			39							sept.		1340	116	W I OI	<u> </u>
rylan how		10a. State 10b. County			1	Oc. City, To	wn or Lo	cation							1	Od. Inside (	
e Ma	Director	MD How	ard			Jes	ssup					-					s 2X No
death with the Maryland me 23e or 28e-f ehow Trium to milited at		10e. Street and Number						10f. Zi	p Code				10g. C	itizen of Wh	at Cour	itry?	
e 236	Funeral	7810 Clark Rd		nit D7 2. Was Dec		or in II C	12.1	Man Dani	2079	·	ain? /Car	adu Vac ar Na		US.		on Indian	
ter de	ņ	<ol> <li>Marital Status</li> <li>Mever Married 2 Married</li> </ol>		Armed F	orces?	erin U.S.	13. 1	f Yes, sp	ocify Cuba	n, Mexican	, Puerto	ecify Yes or No Rican, etc.)	,		White,		
hours after	ρ	3 Widowed 4 Divorced		If Yes, G Year or [	ive No Dates:		1	Yes	2 <b>X</b> No	Specify:				Specify:	,	white	
ING Z IZ I 3-UU30 be filed within 72 hours after death with the Marylan tal Hygiene. d other then "naturel", or freme 23e or 28e-f ehow event, the Mardical Exerts are number to marified at	Completed	15. Deceden			1	16			ial Occupa	ation during most	t of work	ina	16b. h	Kind of Busi	ness/In	dustry	
within 90.	npie	Elementary/Secondary (0-12)	grade		(1-4or 5+)				ise retired		O WOIN	ng					
filed w Hygier other th	ပ္ပံ	12	1 1)	5+			duc	ator				(F)		ducati	on_		
	Be	17. Father's Name (First, Middle,  Thomas Xavi		Coofe	C 10							e (First, Middle	, маіаві	n Sumame)			
d Mari	ဍ	19a. Informant's Name/Relations			31.	10	h Mailin	a Addres	s (Street a			Sass al Route Numb	er City	or Town St	ate Zin	Code)	
Man Id 2 sl Ith an Ith an Itaur Iraur		Gerry E. Keef	65			1:5	17.25	300							aro, 21p	0000)	
Daltimore, Mi permit. Pages 1 and 2 Department of Health a important: if item 27 is any injury or other tra		20a. Method of Disposition	0			20b. Place	of Dispos	sition (Na	me of		1mor 4/7/	nium, A		.ocation - Ci	ity or To	wn, State	
Pages ent of nt: If I		▼ X Burial 2 ☐ Cremation ☐ Donation 5 ☐ Other (S		oval from	State		-		other place V Me			ub irdens	Tim	onium	M	D	
SAILTIMOR Dermit. Pages Department of mportant: If it any injury or of		21. Signature of Figure 8		θ		- aran	22	. Name a	nd Addres	s of Facilit	y						
n ades		Lowell M.	Ler	nmon			l to	emme 0 W.	on Fi Pad	inera onia	Rd.	me of Timor	Dula	neyD	Vall	ey, I	nc.
		23a. Part1. Enter the disease, or shock, or heart failure. List	complic	ations that e cause on	caused the	e death. Do										Approxima Interval Be	tween
Physician		Immediate Cause (Final disease or condition		Dr	STE	Cas	VOTE (	T 11/5	He	- ART	T.	21/1101				Onset and	l Death
/Medical		resulting in death)	<b>(</b> ".	Due to	(or as a c	consequence	e of):	1 10 %	- 1/-	7110-1	- } -/	AILURI	!				· · · · ·
Examiner		Sequentially list conditions,	b.		ARI	)   O M	40	PA	THY								
/	line	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ľ	Oue to	(or as a c	consequence	e ogr):	,	AST	JILOR	\						
xecul and	Examin	that initiated events resulting in death) Last	C.	Due to	(or as a c	consequence	) A (	- )	TUI	7717 +	+						
	dical		l.														
DO tifficati g phy as the	edic																
BOX 6  Beath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23	Bc. If yes, ou		pregnancy □Fetal deat	th 3	Tectonic r	regnancy					23d. Date		,	
s deat	Sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No			nant at tin	ne of death		Other (s						Month	ו	Day	Year
	Ph.	9 Unknown	J									1					
s a gue	2	Part II. Other significant condition	ns cont	tributing to o	death but	not resulting	in the ur	nderlying	cause give	en in Part I.				use contrib			
w requires w requires been sign should be	ted												Yes 2				
has b	Completed											24a. Was	psy	pric	or to co	psy findings mpletion of	available cause of
VICAL MEC sicien: The law certificate has b lirector, page 2 s												1 ☐ Yes	ormed? 2 ₩ N		ath? Yes	2 □ No	
OI VICAL Physician: 1 this certifical tral director, p	Be	25. Was case referred to medical examiner?	-	ospital:					Othe	200		(Check only o					
al this	0	1 Nes 2 No 27. Manner of Death		1 1	Inpatient of Injury		Outpation . Time of		UA	4 🗆 140	rsing Ho	me 5 Resi 28d. Describe		6 ☐Other		")	
ding th.: After	i i	1 ■ Naturaì 5 □ Pendin 2 □ Accident investi		28a. Date (Mor	nth, Day Y	(ear)	Injury	М	28c. Injury Work 1 🗀 \	(?Î Yes 2∐l				,			
I or Attending I atter death. Director: After I in by the funer	lica	3 ☐ Suicide 6 ☐ Could	not be	28e. Plac	e of Injury	- At home,	farm, stre	eet, facto	y, office			28f. Location (	Street a	nd Number	or Rura	l Route Nu	m <i>ber</i> ,
s afte	Certification:	4  Homicide		build	ling, etc.	(Specify)						City or To	wn, Stat	Θ)			
DIVISION  To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifyin (Check only one)	g Physi Exemin	er: On the I	pasis of ea	xamination a	ge, death and/or inv	occurred estigatio	at the tim	e, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s date ar	s) and mann nd place, an	ner as si	ated. the cause	(s)
o the ithin 2 or the omple	Med	29b. Signature and title of certifie	r	and mar	nner state	u.		29	c. License	number			29d. Da	ate signed (	Month.	Day, Year)	
F3F8			1A1	m	en		(D)	T	0001	366	8			-6-			
15	-	30. Name and address of person	who cor	noleted car	ise of dea	th (Item 232	) (Type			_					- (	,	,
ia		AZHER HUS	CA.	N MI				,	d Rd	C	olled	e_Park	N.A	דחכ ת	JιΛ		
Stat	e	31. Date filed (Month, Day, Year)			gistrar'	s Signatura	A	make	,	-,	-1129	LIUIN	, ivi	J	<b>TU</b>		
Registra	ľ	APR 1	7 70	JUbl 🛮	PORLAN	J. J. J.	THE STATE OF THE S	April - April -									

State Registrar

31. Date filed (Month, Day, Year)

APR 1 1 200

32. Registrar's Signature
ORIGINAL

DHMH 17 Rev 1/2001 OCMF 10/2003

			For State Registrar	State of M	1arylan	•	artment of F			giene	1139
			Decedent's Name (First, Middle	, Last)					2. Date of Dea	ıth	3. Time of Death
	Physicia	an	Carol Day	Lundrega	n				April	8 2006	5:30 A M
	/Medic		4a. Facility Name (If not institution				4b. City, Town, o	r Location of Deat		4c. County of Dea	
	Examin	er	Crofton Convai			Ctr		Crofton		Anne A	rundo 1
	-		5. Social Security Number			last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Funeral Director		214-30-1590	1□ M 2√2 F	71	Yrs.	Months Days	Hours Min.	Oct. 6,		hington, DC
			Usual Residence of Decedent		, 1				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1991   1145	
	/land		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation				10d. Inside City Limits
	Man - sh	ţō	Maryland A	ne Arundel			Ode	nton			1 ☐ Yes 2Ã☐ No
	28a	rec	10e. Street and Number				10f. Zip Code			10g. Citizen of What Co	ountry?
	3a or	Q I	2010 Eagle Land	ling Way				21113		United	States
	ns 2	Funeral Director	11. Marital Status	12. Was Deceder		.S. 13.	Was Decedent of H		pecify Yes or No-	14. Race - Ame	
(0	riter	교	1 Never Married 2 Marr	Armed Forces					o nican, etc.)		e, etc.
036	urs a	5	3 ☐ Widowed 4 X Divorced	If Yes, Give Year or Dates	_		1 ☐ Yes 2 🔀 No	Specify:		Specify: W	nite
21215-0036	within 72 hours atter death with the Maryland ene. then "natural" or items 23a or 28a-f show the Medical Examinar reast be redified at	Completed	15. Deceden			16a. Dece	dent's Usual Occup	oation	rkina	16b. Kind of Business	
7	hin 7	ple	(Specify only highest Elementary/Secondary (0-12)	College (1-4o	r 5+)	life.	DO NOT use retire	d)		Space Admi	eronautical
21;	d wit	М	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1		Se	ecretary			Space Admit	
Þ	2 should be filed withir i and Mental Hygiene. Is marked other then reumatic event, the Ms	Bec	17. Father's Name (First, Middle,	Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame)	
Maryland	should be nd Mental marked c	To E	Carl Day					Elizab	eth C	ossler	
ary	shous ama		19a. Informant's Name/Relations	nip (Type, Print)		19b. Maili	ng Address (Street	and Number or Ri	ural Route Numbe	r, City or Town, State,	Zip Code)
	s 1 and 2 should be filed within 72 hours atter death with the Marylan I Health and Mental Hygiene it Health and Mental Hygiene item 27 is marked other then "natural", or items 23a or 28a-1 show item 27 is marked other then "natural", or items treumatic event. The Medical Examination and the right of the medical examination of the medical exam	1	Joyce Phillips	/daughter		2010	Eagle La	nding Wa	v. Odent	on, MD 2111	13
ē,	f Hei f Hei item othe		20a. Method of Disposition		(	Place of Disperse	osition (Name of matory or other pla		Date	20c. Location - City or	Town, State
9	Pages nent of I ont: If it		1 ☐ Burial 2 🛣 Cremation 4 ☐ Donation 5 ☐ Other (S		We s	st Aru	ide1	Apri	1 12, 2006	Odento	n, MD
Baltimore,			21. Signature of Funeral Service			2	2. Name and Addre	ess of Facility			
Ba	permit. Departrimporte any inju	5 (	Dimanica	and or	M0142	27	pnaldson HII Annap	Funeral	Home & C:	rematory, ] on, MD 211	3 <sup>A</sup> •
	_		23a. Part1. Enter the disease, or	complications that caus	ed the deat						Approximate Interval Between
	<b>7</b> 0.11		shock, or heart failure. List Immediate Cause (Final	only one cause on each	ine.	iic.	Harles	100-	Die Die	ougas D	Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a	WOV	110	( WOVY	uceuo	1 accu	way in	SCOX
	Examiner			Due to (or a	as a consec	quence oi).					
н		_	Sequentially list conditions,	b. Due to (or t	as a consac	guenes of):					
	pei	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<		,					
	and and il-trar	хап	that initiated events resulting in death) Last	c. Due to (or a	as a consec	quence of):					
8760,	ate be executed thysician and the burial-transit	ajE									
87	ate hys	dicai		d							
9 ×	death certitics e attending pl od for use as t	by Physician/Me	IF FEMALE:	23c. If yes, outcor	ne of orego	ancv				23d. Date of de	alivery
Вох	ath c	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Feta	al death 3	□Ectopic pregnand □ Other (specify) _	ey .		Month Month	Day Year
0	0 0 0	/sic	1 ☐ Yes 2 No 9 ☐ Unknown	4□ Pregnant 9□ Unknown		ueatri 5	_ Other (specify) _				
9	a 5 5	Phy	Part II. Other significant conditi	one contributing to death	hut not res	sulting in the	inderlying cause of	ven in Part I	23e. Did to	obacco use contribute	to the cause of death?
Ś	w requires that s been signed b should be det	by	Falt II. Other signment contact	one commoding to coun	1 541 1151 151	outing in the			1 🖺 )	Yes 2⊡No 3ÖX	robably 4 Unknown
Records,	inper s	Completed							-		
ပို့		ple							24a. Was autop	osy prior to	utopsy findings available completion of cause of
H	0 - 0	TIO.							perto	rmed? death? 2 X No 1 ☐ Ye	
Vital	ician: Th certificate rector, pag	Be (	25. Was case referred to medica	1				26. Place of De	ath (Check only o	one)	
<b>f</b> V	ding Physician: n. Atter this certific tuneral director,	2	examiner?	Hospital: 1 ☐ Inpa	atient 2	ER/Outpatie	nt 3□ DOA Ot	her: 45 ursing	Home 5 Resid	dence 6 Other (Sp.	ecify)
J Of			27. Manner of Death	28a. Date of I	njury Day Year)	28b. Time Injury	of 28c. Inju	iry at ork?	28d. Describe	how injury occurred	
io	Attending r death. ector: Atter by the tune	atic	Z Accident	gation			M 1	]Yes 2□No			
Division	Atte	ific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	rined 289. Place of	Injury - At I	nome, farm, s	reet, factory, office		28f. Location (S City or Tox	Street and Number or F wn, State)	Rural Route Number,
Ö	atte s afte of in l	Certification:		1							
	Hospitet of the same of the sa	aj	29a. Certifier 1 6ertifyi	ng Physician: To the be Exeminer: On the basi	st of my kn	owledge, dea	th occurred at the t	ime, date and place	e, and due to the	cause(s) and manner a	is stated.
	He He	ledical	(Check only 2 Medical one)	and manner	stated.	ation and/or i	ivestigation, in my	opinion, death occ			
	To the Hospitet or Attent within 24 hours after death To the Funerel Director: completely filled in by the	×	29b. Signature and title of certific	or			29c. Licen	se number	a	29d. Date signed (Mor	nth, Day, Year)
				7			DF	57029	3	4 100	(0
	1.		30. Name and address of person	who completed cause of	of death (Ite	кл 23a) ( <b>Ту</b> ре	, Print)	itxa Ci	ropra.	15.5	
	11		18 Pin	III AVE	. (	tilk	237	MANY	untis	s mo	21401
	St	ate	31. Date filed (Month, Day, Year	32 Beg	istrar's Sign	atore &		1.0	Post	1 12	
	Regist		APR 1	1 2006	Capital .	and of					

		1	For State Registrar	State of Mary		Departr		lealth a	•	Hygiene	006	RESISTANTA BETTER CARANA BETTER CASANA BETTE	40	
	ysicia	n	1. Decedent's Name (First, Middle, Last)  Rose Marie Lusco						2. Date of Month	Death Day	Yea 200		f Death P M	
1	ledica amine		ta. Facility Name (If not institution, give st Bon Secours Hospital	reet and number)		46	o. City, Town, or	Location o	f Death	4c. (	County of De	ath		
Fune Direc		2		7. Age (li	yrs. last b		Under 1 Year onths Days	If Under 2 Hours	Min. Novembe	Birth Year)	9. Birthplece (State or Incountry) Maryland			
Maryland	fledat		Usual Residence of Decedent  10a. State 10b. County  Maryland N/A	10	c. City, To	wn or Location	on zimore					10d. Inside C	ity Limits	
with the	t pe not	Direc	109. Street and Number 2603 E. Northern Park	wav		1	10f. Zip Code 212	214			en of What	Country?		
Ind 21215-0036  be filed within 72 hours after death with the Maryland hall Hygiene. Industrial, or Itema 23e or 28e-f show	Examiner mus	by Fur		2. Was Decedent Eve Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	r in U.S.		s Decedent of H es, specify Cuba Yes XX No	ispanic Origin, Mexican	gin? (Specify Yes or , Puerto Rican, etc.	)	Black, W	merican Indian, hite, etc. hite		
21215-0036 sd within 72 hours affigiene. er than "natural", or	It's Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16	(Give kind life. DO	t's Usual Occup d of work done o NOT use retired memaker	ation during most f)	of working		nd of Busine Own Hom			
Maryland 2 d 2 should be filed the and Mental Hygic it is marked other	tic event,	To Be C	17. Father's Name (First, Middle, Last) Gasper Chiofalo						r's Name (First, Mic Anna Scanda	-	Sumame)			
Mary and 2 sho saith and h	er trauma		19a. Informant's Name/Relationship (Typ Mary Lusco Forrest — Da	ughter	8	544 Ple	asant Pla	ains Ro	ad BAlt	ural Route Number, City or Town, State, Zip Code) BAltimore, Maryland 21286				
Baltimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than	ury or oth		20a, Method of Disposition  1  Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	Most H	oly Red			4/11/2006	Ba	ltimore	or Town, State , Maryland	1	
Balti permit. Departn importe	eny in		21. Signature of Funeral Rervice License  23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one			Leon		ıck, In	c. Baltimo		oad yland i	21214 Approxima		
ds, P.O. Box 68760, irres that the death certificate be executed with attending physician and signed by the attending physician and	lical iner	icai Ex	resulting in death)	Pulmonary Due to (or as a compestive Due to (or as a compestive Due to (or as a comput	onsequence <u>re Hea</u> onsequence	e of): ort Fa e of):	ilure	}				Onset and		
ecords, P.O. Box 68' law requires that the death certificat as been signed by the attending phy	ched for use as	Physician/Medic												
'ds, P	ld be deta	۵	Part II. Other significent conditions con	ributing to death but r	not resulting	in the unde	orlying cause giv	en in Part I		Did tobacco u 1 □ Yes 2 [		e to the cause of Probably 4		
Il Record The law requir	page 2	Completed								Was an autopsy performed?	prior death	autopsy lindings to completion of 1? /es 2 \( \text{No} \)	s available cause of	
# 5 g	- P	ation: To Be	25. Was case referred to medical examiner? 1  Yes 2 No H  27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	28b	Outpatient  J. Time of Injury	28c. Injui	ner: 4 □ Nu				Specify)		
Divis al or Atte s after des	d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.		larm, street	t, factory, office			on (Street an r Town, State		r Rural Route Nui	mber,	
Division ( To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After	pletely fills	Medical (	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of e er: On the basis of e and manner state	camination :	lge, death or and/or inves	stigation, in my	opinion, dea	nd place, and due to th occurred at the t	ime, date and	place, and	due to the cause		
To the within To the	сош	Σ	29b. Signature and title of certified	DAD			29c. Licens		0			onth, Day, Year)		
	0		Steven J.	mpleted cause of dea	tz,	a) (Type, Pri	1305	Seco	ws Hs.	spital	LB.	1/in01	e, KE	
Re	Sta egistr		APR 1 2006	32. Registrar	Signature	Grove.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 128 egina 06 /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner General Hospital County Howard Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 30, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 212 F 92 218-01-8265 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or Iteme 23e or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 425 Madingley Road 21090 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify þ Specify: 3√ Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F John Thomas Loveless Anna Maria Beiswanger Pages 1 end 2 should nent of Health and Men 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 s
Department of Health ar
Important: If Itam 27 Is
any Injury or other trau Joan Lee-Powell, Daughter 425 Madingley Road Linthicum, Maryland 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) 04/06/06 Baltimore, Maryland 21. Signature of Funeral Service Gressee
Triomas Gregor 22 Name and Address of Facility Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** monia 48-72615 yeu /Medical Due to (or as a consequence of) Examiner 515 Sequentially list conditions, any loading to incredisticause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner for as a consumine of or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery ned by the etter 2 | Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 Zenknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performed: 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 ☑No 1 - npatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Aftert Injury 1-Natural 5 Pending death. 1□Yes 2□No I Director: / 2 ☐ Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire filled in Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifig 29c. License number BD0062022 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D Dua 81X LARK B

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** In 2006 Wen 3/0 M /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Advent Moni Garthers Shad Grove 090 6 20mers If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Year) All Min. March 28, 9. Sirthplace (State or Foreign Country) Taiwan 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 M 2 □ F **Funeral** Director 212-69-6471 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code WIT 11802 Milbern Drive 20854 Taiwan Completed by Funeral death permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hyglane. Important: if item 27 is marked other the any injury or other trains. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No Specify: Specify: Asian 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Correspondent News Agency 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jer Lin Lai-Chai Lin ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20854 Fang Chiang / Wife 11802 Milbern Drive, Potomac, Maryland April Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 14, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium, Inc. 2006 Bethesda, Maryland \* 4 Donation 5 Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service License M01420 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) MYXIQ /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the hursal reach. resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown Be Completed | 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No rmeg≀ 2**A** No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\text{\text{Nursing Home}}\) 1 \(\text{Residence}\) 6 \(\text{Other}\) (Specify) ှင 1 Nes 2 No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Medical Certification: erng - 57/4 Division Injun 1 Natural 5 □ Pending 1 ☐ Yes 2 No investigation 6 2006 1130 2 Accident 6 Could not be 3 Suicide 4 ☐ Homicide Location (Street and Number or Rural Route Number City or Town, State) 1/6-2 in 1/0-2 or 2 e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Potomac home mis 20592 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

જ

APR 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRECHER,

2008

1

DME

D09428

2101 medical

w mo DME

mo

32. Registrar's Signature

of the state of

29d. Date signed (Month, Day, Year)

2006

		•	1 - For State Registrar	State of Marylan		artment of F			giene	
			Decedent's Name (First, Middle, Las	1)				2. Date of Dea	ath Day Yea	3. Time of Death
	Physicia			Hazel L.	Lewis			April	9 2006	
)	/Medic Examin	_	4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Dea	ath	4c. County of De	eath
			203 - 3rd Avenu	ie		Balt	imore			Arundel
	Funeral		Social Security Number     6. Security Number		-	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	s. 8. Date of Birt	9. E 8, 1920	birthplace (State or Foreign Country) Ohio
	Director		213 34 43/1	□M 2 <b>□X</b> F 86	Yrs.	Monard Days	1,0070	Mar. 28	8, 1920	Ohio
	pu 🛾		Usual Residence of Decedent  10a. State 10b. County	10c Cib	y, Town or Lo	cation				10d. Inside City Limits
	sho	5	Maryland Anne Ar							1 ☐ Yes 2 🛣 No
	he M	Directo	10e. Street and Number	under	Baltimo	10f. Zip Code			10g. Citizen of What	Country?
	a or	급	203 - 3rd Aven	116			225		U.S.	
	eath	by Funeral	11. Marital Status	12. Was Decedent Ever in U.	S. 13. V			(Specify Yes or No- erto Rican, etc.)	- 14. Race - A	merican Indian,
	r Itan	F	1 ☐ Never Married 2 ☐ Married	Amed Forces? 1 ☐ Yes 2 Z No				erto Rican, etc.)	1 _	
036	al', o	Ď	3 □Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify: V	nite
Q N	within 72 hours after death with the Maryland ene. then "natural", or Itams 23e or 28e-f show he Madical Examinat must be inclified at	Completed	15. Decedent's Ed (Specify only highest grad		16a. Dece	dent's Usual Occup	pation during most of w	orkina	16b. Kind of Busine	ss/Industry
7	thin en	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)		111	C
2	ed wi	S		2 years	Nurs	se		(F) 1 4 4 1 1 1	Health	Care
nd	d oth	Be	17. Father's Name (First, Middle, Last)	Einter				<sub>ame (First, Middle,</sub> telle Ein	Maiden Sumame)	
<u> </u>	Men Merke	မ								7.0.44
Jar	and raum		19a. Informant's Name/Relationship (7 Estelle Ross / I		oute Number, City or Town, State, Zip Code) Woodbine, Maryland 21797					
a)	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itams 23a or 28a-1 show any injury or other traumatic event, the Medical Examinat must be inclined at once.	1	20a. Method of Disposition	20c. Location - City						
2			1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	emetery, crer	natory or other pla	(ce)	Date		
Baltimore, Maryland 21215-0036	t. Partmer		4 Donation 5 Other (Specify			en Mem. I 2. Name and Addre		the same of the sa		ie, Maryland
Bai	Dependent of the population of		21. Signature of Funeral 3 ervice Licen	S <del>00</del>					neral Serv	
			23a. Pert 1. Enter the disease, or comp	lications that caused the deat						ryland 21225 Approximate
Н			shock, or heart failure. List only immediate Cause (Final	one cause on each line.						Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a LEFT B  Due to (or as a conseq		1 CA	26/100	WIN .		
	Examiner	11			401100 017.					
	1	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (c. as a conseq	ue ice of).					
	outed ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C						
ó	te be executed ysicien and le burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):					
3760,		cal		d						
89	Attending Physician: The law requires that the death certifica or death.  •ctor: After this certificate has been signed by the attending phe by the funeral director; page 2 should be detached for use as the funeral director; page 2 should be detached for use as the funeral director.	by Physician/Med	IF FEMALE:				-			
ရွိ	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	Ideath 3[	Ectopic pregnand	y .		23d. Date of Month	delivery Day Year
P.O. Box	the a	SC	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at time of d	leath 5	Other (specify) _				
<u>ď</u>	hat the	P.	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	obacco use contribut	e to the cause of death?
ds,	signe d be	d by	NONINSHIN			ABS ETES		יםי	Yes 2 10 3	Probably 4 Unknown
ŏ	v requ	Completed		N, CONGE				U C 24a. Was	an 24h Were	autopsy findings available
Re	has ge 2	m d	1770000	on j		E NEW	MIL	perfo	ormed? death	
a	n: Th ficate or, pa		25. Was case referred to medical				OC Plans of P		2 B √No 1 □ \	′es 2년No
Ξ	sicia s certi irecto	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA Ot	hac	Home 5 Wesi	dence 6 ☐Other (5	inecify)
ō	y Phy or this oral d		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				how injury occurred	poony/
ion	nding sth. r: Aft	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation		Injury		Yes 2 No			
Division of Vital Records,	Atte or des by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specific	ome, farm, st	reet, factory, office		28f. Location (City or Tox		Rural Route Number,
Ö	tal or rs afte et Di	Ce			···					
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Medical		ysician: To the best of my kno niner: On the basis of examina						
	ithin 2 the mple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date signed (M	onth, Day, Year)
\	5 7 8 H		1 1	more, in	1.		1775	}	-	-2006
7	,									
	6		K. S. D. HALM	completed cause of death (Iter	BRO	OKLYN	MEDIC	AL CONT	EA, 3671	RITCHIE H. WAY
	Sta	ate	31. Date filed (Month, Day, Year)	332. Registrar's Signa	ature			BAUTI	morte, M	021225 .
	Regist		APR 1 1 200	Marker 15	A CONTRACTOR	No.				

			For State Registrar	State of Marylan	•	artment of H <i>rtificate of L</i>			iene' () () (				
	Physici		Decedent's Name (First, Middle, Last)     LEROY	н.	L.OW	ENTHAL,	JR.	2. Date of Death	Day Ye	3. Time of Death 11:04 A M			
	/Medic Examin		4a. Facility Name (If not institution, give : SINAI HOSPITAL			4b. City, Town, or	Location of Death		4c. County of D				
	Funeral Director		5. Social Security Number 6. Sec	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth JULY 24	Year 9.	Birthplace (State or Foreign Country) MD			
	ō		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	ty, Town or Lo					10d. Inside City Limits			
	Ba-fe	Funeral Director	MD N/A		BAL	TIMORE				1 X Yes 2 □ No			
	with the	Dir	10e. Street and Number 5943 WESTERN RUN	DRIVE		10f. Zip Code	21209	11	0g. Citizen of Wha	USA			
	death	nera		12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba		pecify Yes or No-		American Indian, Vhite, etc.			
9000	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other than "natural", or items 23a or 28a-f ehow other traumatic event, the Medical Examinar must be notified at	ρ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	1 XYes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Specify:	WHITE			
21215-0036	thin 72 h e. an natu Medical	(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)							16b. Kind of Busine	ess/Industry			
121	filed within Hygiene. Ither than int, Ithe We	Con	17. Father's Name (First, Middle, Last)		SALES	PERSON	18 Mother's Nam	ne (First, Middle, N	CLOTHING				
Maryland	should be fill and Mental H marked oth	To Be	LEROY		WENTHA		HILDA		•	GLASER			
	and 2 sho salth and n 27 ie m		19a. Informant's Name/Relationship (Ty NINA MERKEL / DA	UGHTER	13 L	ACOSTA CO		WSON, MD	21204				
Baltimore,	permit. Pages 1 and 2. Department of Health at Importent: If item 27 is any injury or other tratonce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	emoval from State	semetery, crer	sition (Name of matory or other plac			20c. Location - City				
OHEB SHALOM CEMETERY 04/09/2006 BALTIMORE.  21. Signature of Funeral Service Cicenses  22. Name and Address of Facility SOL LEVINSON & BROS.													
B	permit. Departr Importe any inje		Millout 15	8900 REISTERSTOWN ROAD - PIKESVILLE, M									
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)										
I	Examiner	_	Sequentially list conditions,	Due to (or as a conseq		,							
ī	cuted nd ransit	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	juence or):								
68760,	ficate be executed physician and s the burial-transit	edical Examin	resulting in death) Last	Due to (or as a conseq	quence of):								
	<u>≔</u> ⊘ α												
O. Box	that the death certifi ed by the attending detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year			
, P.O	law requires that the as been signed by th 2 should be detache	y Ph	Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribu	te to the cause of death?			
ords	w requires that been signed to should be det	sted t								Probably 4 Unknown			
of Vital Records,	The law ate has b page 2 sl	Completed by						24a. Was a autops perform	ned? prior	e autopsy findings available to completion of cause of h? Yes 2 \sum No			
Vita	Physician: rthis certific ral director,	Be	25. Was case referred to medical examiner?	lospital:	1	t all pos Othe		ith (Check only of					
on of	The state of the s									Specify)			
Division	i or Attending after death. Director: After 3 in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special		reet, factory, office		28f. Location (St City or Town	reet and Number on, State)	r Rural Route Number,			
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier (Check only one) 154 Certifying Phy 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, deat ation and/or in	h occurred at the tim vestigation, in my of	ne, date and place pinion, death occu	, and due to the carred at the time, d	ause(s) and manne ate and place, and	er as stated. due to the cause(s)			
	To the within To the comple	Me	29b. Signature and title of certifier	Red C	),	29c. License	number	2	9d. Date signed (A	fonth, Day, Year)			
1	9		30. Name and address of person who co	ompleted cause of death (iter	n 23a) (Type,	Print)	00-1			0			
-			Dr. Rudikoff,	Baltamert	, MI	)							

DHMH 17 Rev 1/2001

Registrar

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

DR. TARIQ MAHMOOD

APR 1 1 2006

2006

GORDON MADISON

2300 DULANEY VALLEY RD.

29c. License numbe

4372

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

110106

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

		1- State O' Registrar		partment of Health and ertificate of Death	Mental Hygie		1146
Physici	on.	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
Physici /Medic			SHALL			6, 2006	2:30 a M
Examin	ner	4a. Fecility Name (If not institution, give street and nur.	nber)	4b. City, Town, or Location of Dea	th	4c. County of Death	222
80,00 O E	.00	8308 Stewart Court  5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	Laurel  J If Under 1 Year   If Under 24 Hrs	Data of Digit	Anne Arui	
Funeral Director		163-05-2629	7. Age (in yrs. last birthda) Yrs.	Months Days Hours Min		1916 Peni	place (State or Foreign ntry) nsylvania
ס		Usual Residence of Decedent			5 5 1 7		
irylan show dat	_	10a. State 10b. County	10c. City, Town or I			1	10d. Inside City Limits
8a-1s	Director	Maryland Anne Arundel	Laurel				1 □ Yes 2⁄€XNo
death with the Maryland ms 23a or 28a-f show rmust be notified at	Dir	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cour	ntry?
eath i	erai	8308 Stewart Court  11. Marital Status 12. Was Dece	edent Ever in U.S. 13	20724  . Was Decedent of Hispanic Origin? (	Specify Ves or No-	U.S.A.	an Indian
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Mental Hygiene. Pages them 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event. The Medical Examinar must be notified at once.	by Funeral	1 Never Married 2 Married 1 X Yes  1 Widowed 4 X Movorced 1 X Yes II Yes, Giv	rces? 2 No WWII	If Yes, specify Cuban, Mexican, Puel  1 ☐ Yes 2 🛣 No Specify:	to Rican, etc.)	Black, White,  Specify: Wh:	etc.
2 hou	ted	15. Decedent's Education	16a. Dec	edent's Usual Occupation	168	o. Kind of Business/In	dustry
thin 7	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1	-4or 5+)	re kind of work done during most of wo DO NOT use retired)	nrking		
ed will ygien ver th	Con	Grade 8	Plant	Engineer		Distiller	Y
d be fill ental Hy ced oth	Be	17. Father's Name (First, Middle, Last)	den Sumame)				
narke natic	۴	William F. Marshall		2 / 1			
d 2 sl th and 7 is r	N i	19a. Informant's Name/Relationship (Type, Print) William L. Marshall, Jr/		ling Address <i>(Street and Number or R</i> 3 Stewart Court I	urai Houre Number, C. Jaurel, Mar		7 2 <b>4</b>
Heal Heal tem 2		20a. Method of Disposition	20b. Place of Dist	position (Name of		. Location - City or To	
ages ent of nt: if i		1 ☐ Burial 2 [XXemation 3 ☐ Removal from 9 4 ☐ Donation 5 ☐ Other (Specify)	State	ematory or other place) adel Crematory 4/	7/2006	denton, Ma	arvland
permit. Pages Department of Mportant: If it Iny injury or o		21. Signature of Funeral Service Licensee		22 Name and Address of Facility Donaldson Funeral		i	ar y rana
Depariment of the part of the		1635km /	M00770	313 Talbott Avenu			20707
*		23a. Part1. Enter the disease, or complications that c shock, or heart failure. Hist only one cause on e	aused the death. Do not e ach line.	nter the mode of dying, such as cardia	c or respiratory arrest.		Approximate Interval Between Onset and Death
Physician /Medical		resulting in death)	nemic Cardion	nyopathy			3 years
Examiner		Due to (	or as a consequence of):	Diagram			E WOOKS
	er	Spoupotist's list conditions	onary Artery or as a consequence of):	Disease			5 years
uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events					
e exec			or as a consequence of):				
ate be executed hysician and the burial-transit	dical	d.					
ertific Jing p	Mec	IF FEMALE:				1	
that the death certificed by the attending it detached for use as	Physician/Me	in the past 12 months?		□Ectopic pregnancy		23d. Date of delive Month	ery Day Year
he de the c	ysic	1 Yes 2 No 4 Pregn 9 Unknown 9 Unknown		Other (specify)			
that hed by deta	y Ph	Part II. Other significant conditions contributing to de	eath but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the	he cause of death?
w requires that s been signed t s should be det	d by	Hypertension			1 🗌 Yes	2 □ No 3KV rot	oably 4 DUnknown
swrec s bee	Siete	COPD			24a. Was an	24b. Were auto	psy findings available mpletion of cause of
The la	Completed				autopsy performed 1 ☐ Yes XX	? death?	mpletion of cause of
ician: ] sertificat ector, pi	Bec	25. Was case referred to medicat examiner?		26. Place of De	ath (Check only one)		7171
Phyaic rthis ce	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ I	npatient 2 ER/Outpatie		Home 5 XXesidenc	e 6 □Other (Specif	(y)
ing P	00:		of Injury h, Day Year) 28b. Time Injury	Work?	28d. Describe how i	injury occurred	
or Attending ter death. irector: After or by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	of Injury At home form	M 1 Yes 2 No	28f Location (Street	t and Number or Rura	al Pouto Mumbos
i or A after Direction by	Certification;	determined 288. Place	of Injury - At home, farm, s ng, etc. <i>(Specify)</i>	птеет, тастоту, оптов	City or Town, S		ar noute wumper,
To the Hospital or Attending Phyaician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier Certifying Physician: To the	best of my knowledge, dea	ath occurred at the time, date and plac	e, and due to the caus	e(s) and manner as s	tated.
n 24 ł n 24 ł ne Fu sletely	Medical	(Check only one) 2 Medical Examiner: On the ba	asis of examination and/or	nvestigation, in my opinion, death occ	urred at the time, date	and place, and due to	o the cause(s)
To the within To the comp	Me	29b. Signature and title of certifier	PATTENDING	29c. License number	29d.	Date signed (Month,	Day, Year)
		are well	PHYSICIAN	D0057216		April 7,	2006
1241		30. Name and address of person who completed caus	e of death (Item 23a) (Type	, Print)			
10.			0 Ft. Meade	Road #209 Laure	el, Marylar	nd 20724	
Sta Registr		31. Date filed (Month, Day Year) 1 2005 32. R	SHALL A	Sparke			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene
Registrar | For Amend #5 Per INF G859 9/14/06 Certificate of Death | Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** J. GLENN MORRIS, SR. 2006 APRIL 6, 9:15 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE GILCHRIST CENTER TOWSON Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 252507-7723 15☑ M 2 ☐ F 88 252 06 7723 Director 1/30/1918 GEORGIA Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County r then "naturel", or Iteme 23a or 28a-f show the Medical Examinar must be notified at Mo Yes 2 No N/A BALTIMORE CITY Director MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21210 USA 107 SAINT JOHNS ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify À 3 ₩ Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) MINISTER CHURCH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) J. MARTIN MORRIS EDNA CHRISTIAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s of Health an 107 SAINT JOHNS ROAD BALTIMORE, MD 21210 J. GLENN MORRIS, JR./SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State CLINTON CEMETERY 4/10/2006 CLINTON, MS 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. al 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 Ant1. Enter the disease, or complications that cause the death. Oo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): hypertensin Jers disease or condition resulting in death) /Medical Examiner pulmonary Fibrasis TONS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Due to (or as a consequence of) ed by the attending physicien detached for use as the burial 68760 certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. heart failure Cayeston 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown cete has been sig , pege 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificete 2 No 1 ☐ Yes : After this certification funeral director, 25. Was case reterred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Dother (Specify) NOS PIQ 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Injury 1 Matural 5 Pending death. 1 ☐Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide or A To the Hospital c within 24 hours af To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1) 58 303 APRIL 7 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMON CHAMES, M ST BALTHURE US 21204 6601 N. Charles

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

APR 1

2006

mark)

32. Registrar's Signature

		1 - For State of N	-	epartment of H		ental Hygier		
		Decedent's Name (First, Middle, Last)			2	2. Date of Death	Day Vast	3. Time of Death
Physic		Doris Louveni	a Mitze	. 1		Month April 6.	Day Year 2006	8:35 P M
/Medi Exami		4a. Facility Name (If not institution, give street and number			Location of Death		4c. County of Deat	h
LXUIII		713 Maiden Choice Lane, A	nt 1407	Catons	sville		Ва	ltimore
Funeral		5. Social Security Number 6. Sex 7. A	ige (In yrs. last birti	hday) If Under 1 Year	If Under 24 Hrs. g	B. Date of Birth	9. Birt	hplace (State or Foreign
Director		217-12-8828 1□M 2阡F	83	Yrs. Months Days	Hours Min.	(Month, Day, Ye JAN 20, 1	1923 Ma	ryland
D		Usual Residence of Decedent						
rylar how		10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
B Ma	cto	Maryland Baltimore		Catons	sville			
ith th	Funeral Directo	10e. Street and Number		10f. Zip Code		10g.	Citizen of What Co	ountry?
23a	-B	713 Maiden Choice Lane, A	pt. 1407		21228		USA	
r des	Ine	11. Marital Status 12. Was Deceder	T Ever in U.S.	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spec in, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit	
or It		f Yes. Give		1 ☐ Yes 2 🎇 No	Specify:		Specify: W	nite
ural;	d by	3 ☐ Widowed 4 ☐ Divorced Year or Dates		Description of Contract	-Ni	105	. Kind of Business	
nat 72	Completed	15. Decedent's Education (Specify only highest grade completed)		Decedent's Usual Occupi (Give kind of work done of life. DO NOT use retired	durina most of working	7	. Kind or Business	medstry
withie Liber	Ę	Elementary/Secondary (0-12) College (1-40	r 5+)	Homemaker	,		Own :	Home
IIIG 4 14 13-UU30  be filed within 72 hours after death with the Maryland tal Hygiene.  d other than "natural", or Items 23a or 28e-f ahow event, the Medical Exerting trast be retilified at		17. Father's Name (First, Middle, Last)		HOMEMEREE	18. Mother's Name (	First, Middle, Maid		HOME
ortal bed ortal	Be	James Leroy Justice			,	le Wheele		
d Me mark matic	٢	19a. Informant's Name/Relationship (Type, Print)	19h	Mailing Address (Street		_		Zip Code) 21228
MCB d2s d2s than 7 is u		Robert E. Mitzel/Husband		3 Maiden Ch				21220
T an 1 an Healt		20a. Method of Disposition	20b. Place of	Disposition (Name of	Da		. Location - City or	
ages nt of .: If it		1 Burial 2 Cremation 3 Removal from State	8 '	y, crematory or other place.		26	D-1+	···· MD
Salitino  Sermit. Pages Department of mportant: If it iny injury or o		* 4 □ Donation 5 □ Other (Specify)  21. Signatury of Funeral Service Licensee	recto	Crematory,			Baltimo	
DEBILLINOTE, INICITY ISTICA Z.I.Z.1.5-00.50 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural", or Itams 23a or 28e-f ahow any injury or other traumatic event, the Medical Examinal Traust be inclined at any injury or other traumatic event, the Medical Examinal Traust be inclined at once.		2 dwnd A rysel		299 Freder	<sup>ss of Facility</sup> Cre rick Road	mation So	ociety of	1 MD, Inc.
		Edward A Gregorchik  23a. Part 1. Enter the disease, or complications that caus	ed the death. Do r				ie, m 21	Approximate
		shock, or heart failure. List only one cause on each	ling.	/				Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	195704	le Miny	can	U		
/Medical Examiner		Due to (or a	a consequence	of):				1
		Sequentially list conditions, if any leading to immediate Due to (or a	is a consequence of	of)·				
lsit ed	ine	cause. Enter Underlying Cause (Disease or injury	a a consequence	51).				
and and II-trar	Examiner	that initiated events c.	is a consequence of	of):				
ate be executed hysician and the burial-transit								
wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit.	dlcai	d						
Certifica	/Me	IF FEMALE: 23c. If yes, outcom	ne of pregnancy				23d. Date of de	livery
death cer death cer a attendir	hysiclan/M	in the past 12 months?	2 Fetal death at time of death	3 □Ectopic pregnancy 5 □ Other (specify)	,		Month	Day Year
e fight	ysic	1 Yes 2 No 9 Unknown						
Ords, F.C. requires that the een signed by th hould be detache	0	Part II. Other significant conditions contributing to death	but not resulting in	the underlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
law requires as been signed 2 should be	d by					1 ☐ Yes	2.21√0 3 □ P	robably 4 DUnknown
v requested	Completed					24a. Was an	24b. Were a	utopsy findings available
has 6 2	E D					autopsy performed	prior to death?	completion of cause of
on or Vital F ling Physician: The P. After this certificate funeral director, pag						1 Yes 24	No 1 ☐ Yes	2 □ No
r VICAL ysician: T is certificat director, pa	Be	25. Was case referred to medical examiner?  Hospital:	a 🗆 ED10	Oth	er: 4 ☐ Nursing Hom		0 []Oth - 1 (G-	
Phys this	<u>۱.</u>	T Tes 2 No T I Inpa	itient 2 ER/Ou	tpatient 3 DOA DOA Time of 28c. Injury		e 5∟ Hesidence 3d. Describe how i		(CITY)
Jing After fune	lo Lo	1 ⊟Natural 5 ☐ Pending (Month, I	Jay Year)	njury Wor			1-7	
ISIC ttend death death ctor: / the	ca	3 Suicide 6 Could not be 390 Place of	niury - At home, fa	rm, street, factory, office		3f. Location (Stree	t and Number or R	ural Route Number,
DIVISION  or Attending after death. Director: Afte	ertification:	4 Homicide determined building.	etc. (Specify)	,,,,		City or Town, S	tate)	
pital ours narel	O	29a. Certifier 1 Certifying Physicien: To the be	st of my knowledge	a. death occurred at the tin	me, date and place, ar	nd due to the caus	e(s) and manner a	s stated.
UNISION OF VITAL To the Hospital or Attending Physician: within 24 hours after death. To the Funarel Director: After this certifica completely filled in by the tuneral director, t	edical	(Check only 2 Medical Examiner: On the basis	of examination an	d/or investigation, in my o	pinion, death occurred	d at the time, date		
o the	Me	29b. Signature and title of cegifier	1_	29c. Licens	e number	29d.	Date signed (Mon	h. Day, Year)
F > F 0		) Aram	7	00	202004	-0	4/7/	06
/	1	30. Name and address of person who completed cause o	f death (Item 23a)	(Type, Print)			1	2 00
5		Van un 71	1 Ma	eden /	ione L	RUE	Calle	mirelle
s	tate	31. Date filed (Month, Day, Year) 32. Regi	strar's Signature	Hoads				MA
Regis		APR 1 1 2006	Will del	(Type, Print)				7/778

			1 - For State Registrar	State of Ma	aryland / Depa	artment of F			giene	06	Professional Company	49
	# PI	2	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Year	3. Time o	f Death
	Physici /Medic		Robert P	aul Man	n	,		Apri1	6, 20	006	5:50	) P <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, give s.			4b. City, Town, o		ath	4c. Co	unty of Death		
			917 Rolandvue Roa  5. Social Security Number 6. Sex		e (In yrs. last birthday)	If Under 1 Year	OWSON  If Under 24 H	rs. 8 Date of Birt	h	Baltin		or Foreign
- 36	Funeral Director			M 2□F	76 Yrs.	Months Days	Hours M		y, Year) 1929		place (State ontry) Sy <u>lvan</u>	
JP-1	P.		Usual Residence of Decedent									
	show show	٦	10a. State 10b. County		10c. City, Town or Lo						10d. Inside C 1 ☐ Yes	2 X No
	the M	Directo	Maryland Baltimo	re		Towson			10a Citizer	of What Cou		
	3a or		917 Rolandvue Roa	bd			204			USA	,	
	death me 2	Funeral		Was Decedent Armed Forces?	Ever in U.S. 13.		lispanic Origin?	(Specify Yes or No		Race - Ameri		
9	or its		1 Never Married 2 Married	1 Yes 2 1	No		Specify:	ento rican, etc.)	Sp	Black, White, ecify:	etc.	
Ö	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow ta Madical Examiner must be nailified at	d by	3 Widowed 4 Divorced	Year or Dates:	1949-55	dent's Usual Occup				Wh of Business/Ir	ite	
ייִ קי	in 72 n "nat	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give	kind of work done DO NOT use retired	during most of v	working		ivate		
212	d with	lmo:	Elementary/Secondary (0-12)	College (1-4or 5		Attorney				actice	Law	
nd	al Hyg	Вес	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,	Maiden Su	mame)		
<u> </u>	ould to	10	0. Paul Mann					oy M. Fos				
Mar	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23e or 28a-1 show or other traumatic event, the Medical Examinat must be natified at	6	19a. Informant's Name/Relationship (Typ	.000		ng Address <i>(Street</i> Ro1andvue		Rural Route Number			o Code)	
ē,	permit. Pages 1 and 2 Department of Health s Important: if item 27 is any injury or other tra <u>once</u> .		Dorothy N. Mann/Wi 20a. Method of Disposition		20b. Place of Dispo cemetery, crei			Towson, M		U4 ion - City or T	own, State	
ē	Pages nent of int: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Metro Cre			7/06	Ralt	imore.	MD	
Baltimore, Maryland 21215-0036	partm porta y inju		21. Signature of Euperal Service Picense	θ //	22	2. Name and Addre	ss of Facility	Cremation	Soci	ety of	MD, I	nc.
<u> </u>	8858		Edward A Cre	gorchik	2	299 Frede	rick Ro	ad Balti	more,	MD 21	228	
188			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused	the death. Do not entine.	er the mode of dyir	ig, such as card	liac or respiratory ar	rest,		Approxima Interval Be Onset and	tween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	(	OPL	)					011001 4110	
	Examiner		1	Due to (or as	a consequence of):							
	2	Jer	Sequentially list conditions, if any, leading to immediate		a consequence of):	· · · · · · · · · · · · · · · · · · ·						
1	cuted nd ransit	Examiner	Cause (Disease or injury that initiated events									
ő,	cate be executed oblysician and the burial-transit	Ex	resulting in death) Last	Due to (or as	a consequence of):							
8760	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	dicai	d							_		
× 6	leath certific attending p	Physician/Med	IF FEMALE:	3c. If yes, outcome	of pregnancy				23d	. Date of deliv	arv	
Вох	death atter	clar	23b. Was decedent pregnant in the past 12 months?  1 \( \subseteq \text{Yes} \) 2 \( \subseteq \text{No} \)	1 ☐ Live birth 4 ☐ Pregnant at		Ectopic pregnancy Other (specify)	<u>'</u>		200	Month		Year
P.O.	that the de led by the a detached i	hys	9 Unknown	9□ Unknown								
	signed I	by P	Part II. Other significant conditions con	tributing to death b	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	/	contribute to t		
ord	w requir been si should	ted						- 💢	Yes 2□N	lo 3 Pro	bably 4 🗌	Unknown
ec	e taw has b	Completed						24a. Was	an 2 sy rmed?	4b. Were auto prior to co death?	opsy findings ompletion of c	available cause of
a F								1 ☐ Yes	2 No	1 🗆 Yes	2 No	
<u> </u>	Physician: this certificating all director, I	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	ent 2 ER/Outpatier	oth Oth		Death (Check only of g Home 5 Resid	1	Other (See	6.1	
ō	Attending Physician: r death. ector: After this certificaby the funeral director.	n: To	27. Manner of Death	28a. Date of Inju (Month, Da				28d. Describe I			'9/	
0	ath. rath. rr: After	atio	1 Matural 5 Pending investigation	(Workin, Da	y rear/ injury		Yes 2 □ No					
Division of Vital Records,	after deatl Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At home, farm, str c. (Specify)	reet, factory, office		28f. Location (3 City or Tox	Street and N vn, State)	lumber or Rur	al Route Nun	nber,
Ω	pitel c		29a. Certifier 16 Certifying Phys	alon. Talthu back	of any big and allow decision	e man han e seren en	and the second second	San and the san are	en in Mak an	Market Francis	distant.	
	Mospitel 24 hours a Funerel etely filled	edical	(Check only one)	er: On the basis of	of my knowledge deal f examination and/or in ated.	vestigation, in my o	pinion, death o	courred at the time,	date and pla	ice, and due l	to the cause(:	s)
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Me	29b. Signature and title of certifier	λ		29c. Licens	e number		29d. Date s	igned (Month,	Day, Year)	
)			mn	87	NS	Do	3254	7	Apri	1 7, 20	006	
	30		30. Name and address of person who con		leath (Item 23a) (Type,	Print)				, , ,		
	A service		31 Date filed (Month Day Year)	nom Bel	6/	of n.	Charle	J 54	1200	t K	>	
	Sta Registi		APR 1 1 2006	az Hegistr	ar's Signature							

Amend item#5, perFH, 0855 5/5/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** MANSFIELD TH 06 13:40 M 2006 /Medical 4a Facility Name (If not institution, give street and number), 4c. County of Death 4b. City, Town, or Location of Death Examiner 10PKirs HIMOLE
Year | If Under 24 Hrs. N/A 8. Date of Birth (Month, Day, Year) JUNE 27, 1 i. Social Security Numb 462<del>-76-</del>225 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 ☐ M 2 🖫 F -2251 Director Yrs 58 1947 NEW MEXICO Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits rthan "neturel", or Items 23s or 28s-1 show the Medical Examiner must be notified at 1X Yes 2 □ No TEXAS COLLIN DALLAS Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 75252 6011 MARLOW AVE. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 1 No If Yes, Give A Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. ģ Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) AGENT REAL ESTATE 12 If Item 27 is marked other or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be s 1 and 2 should be ti. I Health and Mental H Item 27 Is marked ott R.W. STANDEFER FRANCES E. KHROHN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 le
eny Injury or other trau 6011 MARLOW AVE., DALLAS, TEXAS MIKE MANSFIELD/HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ♥ Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/11,2006 Dallas, Texas Restland Mem. Park 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 21. Signature of Funeral Service Licensee essice 23a. Part 1. Enjer the disease, or complications that shock, or heart failure. List only one cause of used the death. Do not enter the mode of dving, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) ACEND CARCINGMA **Physician** YEAR /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and I for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregpant ned by the atter 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? 2□ No 1 ☐ Yes 2 1 No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifics completely tilled in by the tuneral director, § 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) MEDICAL DOCTOR RES-000 APRIL 06, completed cause of death (Item 23a) (Type, Print) WOLFE STREET, BALTIMORE, MARYLAND ARORA ,600 N 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

		1 = For State Registrar	State of Marylan		artment of I rtificate of			iene og. No.	Marketonian property of the second property o
Physic		Decedent's Name (First, Middle, Last)  FRANCTS OIIA	L MILLER, JR				2. Date of Death Month APRIL 8		3. Time of Death 1:35am
/Med Exam		4a. Facility Name (If not institution, give s JOHNS HOPKINS BAYV	reet and number)	•	4b. City, Town, o	or Location of Dea	th	4c. County of D	
Funera Directo		5. Social Security Number 6. Sex 219-66-6454	7. Age (In yrs. 51	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		, 1954 WE	Birthplace (State or Foreign STVIRGINIA
Maryland f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  MD BALTIMORI		y, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 XXVo
with the 3a or 284	I Director	10e. Street and Number 757 ALDWORTH ROAD			10f. Zip Code	21222	10	0g. Citizen of What USA	Country?
ING Z I Z I 3-UU30  be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28a-1 show event, the Medical Examir or must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2 ☐ No If Yes, Give X Year or Dates:		Was Decedent of Hispanic Origin? (Specify Yes If Yes, specify Cuban, Mexican, Puerto Rican, et 1 ☐ Yes 2 ☐ No Specify:			14. Race - A Black, W Specify:	merican Indian, Ihite, etc. WHITE
Mar y Idilio K.I.K. I 5-0050 d.2 should be filed within 72 hours af th and Mental Hygiene. ?? is marked other than "naturel", or traumatic event, the Madical Exert	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 8TH		(Give life.	dent's Usual Occu kind of work done DO NOT use retire ANDER	during most of we	orking	16b. Kind of Busine	
aryland Z should be filled and Mental Hygis s marked other umatic event, I	To Be C	17. Father's Name (First, Middle, Last) FRANCIS Q. MILLER	, SR.			18. Mother's Name (First, Middle, Maid VIRGINIA LOUISE V			
Hear Hear other		19a. Informant's Name/Relationship (Typ.  STACEY MARSH/DAUG)  20a. Method of Disposition  1	HTER	757 Place of Dispo	•	RD., BA	Rural Route Number, LTIMORE, Date		21222
Dailimol permit. Pages Department of Important: If I any njury or		4 Donation 5 Other (Specify)  21. Signature of Funeral Service License	CE	22		ess of Facility C		ZEILER 8	SON, INC. ND 21224
Physician /Medica Examine		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	ations that caused the deat e cause on each line.  MYCCA  Due to (or as a conseq  At here son le	RDIA uence of):	L INF	ARCTIO	N	əst,	Approximate Interval Between Onset and Death
icate be executed physician and sthe burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
The COLUS, T.O. DOX of The law requires that the death certific the has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	Ideath 3	⊒Ectopic pregnanc □ Other (specify) _	у		23d. Date of Month	delivery Day Year
w requires that been signed b should be deta	þ	Part II. Other significant conditions con	inbuting to death but not res	ulting in the u	nderlying cause gi	ven in Part I.			e to the cause of death?  Probably 4 □Unknown
DIVISION OT VITAL HECOTOS, I or Attending Physician: The law requires I after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be a	Completed						24a. Was an autops perform	y prior ned? death	autopsy findings available to completion of cause of 1? Yes 2 \(\sumbolear\) No
OT VICAL P Physician: Th or this certificate eral director, pag	n: To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  27. Manner of Death	ospital: 1 ☐ Inpatient 2 ☑ 28a. Date of Injury (Month, Day Year)	ER/Outpatier	f 28c. Inju	her: 4 🗌 Nursing	eath (Check only on Home 5 - Reside 28d. Describe ho		Specify)
UNISION OT VITA  To the Hospitel or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifica completely filled in by the funeral director,	Certification:	1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, st	M 1	rk? ]Yes 2 □No	28f. Location (St. City or Town	reet and Number of	Rural Route Number,
Hospitel 24 hours a Funeral C	Medical Ce		ician: To the best of my kno er: On the basis of examina and manner stated.						
To th within To the	Me	29b. Signature and title of certifier	lus MD			se number		Opril 1	•
2		30. Name and address of person who con Reed D. Riley, 1	ND 4924	n 23a) (Type, Camı	Print)  Divell Ba	ulevard	Baltimo	ve, Mory	0, 2006 and 21236
S Regis	tate trar	31. Date filed (Month, Day, Year)  APR 1 1 200	32 Pegistrar's Signa	ature	346			7	

McGragov, Mal colun Baltimore, Maryland 21215-0036

1	
	1
10	6
68760,	
30 x 68	
.O.E	
Records, F	
Vital	
o	
Division	

	1 - State Registrar		-	partment of H ertificate of I		Reg.	6000	1 1 5 2
/sician ledical	1. Decedent's Name (First, Middle, Malcolm Alpheus					A DV	9 2000	3. Time of Death
aminer	4a. Facility Name (If not institution, s BALTIMORE WA	give street and number)	and Oca	1	Location of Death	5	AUNE AR	ath
eral ctor		. Sex 7. Age (	In yrs. last birthd	ay) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, You 11-5-19)	9. Bi	rthplace (State or Fore ountry)
4	Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town o	Location		11 0 17		10d. Inside City Lim
Director	MD Anne	Arundel	Glen Bu	rnie		10g	. Citizen of What C	1 Tyes 2 Tountry?
al Di	11 Leymar Road			21060			U.S.A.	
Examiner: sast to notified at I by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3€GWidowed 4 □ Divorced	12. Was Decedent Even Armed Forces? d □ □ Yes 2/□ No If Yes, Give Year or Dates:	er in U.S.	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes ※XXNo	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh Specify:	
any injury or other traumatic event, the Madical Exa	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	(G	cedent's Usual Occup ive kind of work done on e. DO NOT use retired	ation during most of workin )	ng 16	b. Kind of Busines	s/Industry
e e	Elementary/Secondary (0°12)	4		gineer			Westingh	ouse
event Be (	17. Father's Name (First, Middle, La				18. Mother's Name		iden Sumame)	
To	Orson E. McGrego				Florence			
Te u	19a. Informant's Name/Relationship			ailing Address (Street				Zip Code)
Ĭ	Mrs. Marcia Kin 20a. Method of Disposition			.68 Railroa			1D 21122 c. Location - City o	r Town State
o 20	Burial 2 XCremation 3	I □Removal from State	cemetery,	sposition (Name of crematory or other place	e)	20	c. Location - City o	1 70WII, State
lary lary	4 □ Donation 5 □ Other (Spe	16	Chesape	ake Cremat				ille, MD
any in	21. Fignature Funeral Service Lin		mo1364	22. Name and Address				
b burial-transit using using the control of the con	shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Einter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	consequence of):					Interval Between Onset and Death
should be detached for use as the leted by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown			23d. Date of delivery Month Day Year				
<b>6</b> 8	Part II. Other significant condition	s contributing to death but	not resulting in th	e underlying cause giv	en in Part I.		cco use contribute 2 □ No 3 □ F	to the cause of death Probably 4 Hunkno
2 2						24a. Was an autopsy performe	prior to	
luneral director, page	25. Was case referred to medical examiner?  1 Yes 2 No  27. Mynor of Death  1 Natural 5 Pending	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y	2 ☐ ER/Outpa 28b. Tim (ear) Inju	e of 28c. Injur	/ at </td <td></td> <td>e 6 □Other (Sp</td> <td>ecify)</td>		e 6 □Other (Sp	ecify)
completely filled in by the funeral Medical Certification: 1	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be One Blace of Injury	- At home, farm (Specify)	M 1 □	Yes 2 □No	28f. Location (Stree City or Town, S		Rural Route Number,
Medical	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of staminer: On the basis of each manner state	xamination and/o	eath occurred at the tir r investigation, in my o	ne, date and place, a pinion, death occurre	ed at the time, date	and place, and du	ue to the cause(s)
E S	30. Name and address of person w	E. Wich	MI	29c. Licens	(1365	A	Date signed (Mor	2006
V	30. Name and address of person w	ho completed cause of dea	th (Item 23a) (Ty	pe, Print)	1 Dieil	1	R	MD 2101

			, roi	partment of Health and Mertificate of Death	ental Hygie	ZUUD	53	
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
	Physici		Celia Rosedna McMahan		Month 4-4-200	Day Year	10:45 P <sup>M</sup>	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4-4-200	4c. County of Deal		
	LAGITIT	Ç.	Crofton Convalescent Center	Crofton		Anne Arundel		
	Funeral		Social Security Number     6. Sex     7. Age (In yrs. last birthda)		8. Date of Birth (Month, Day, Y	9. Birt	thplace (State or Foreign buntry)	
	Director	1	214-16-9523 1 M 2 F 89 Yrs.	Working Day's Flours Will.	4-21-19			
- 33-	pu 🔪		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	ocation			10d. Inside City Limits	
	aho	ō					1 ☐ Yes 2 ☐ No	
	the N	Director	MD Anne Arundel Severn  10e. Street and Number	10f. Zip Code	100	. Citizen of What Co	A	
	with with	ğ					ountry's	
	leath	Funerai	7959 Telegraph Road, Lot 28  11. Marital Status 12. Was Decedent Ever in U.S. 13	21144 Was Decedent of Hispanic Origin? (Spec	ofy Yes or No-	U.S.A.	erican Indian,	
(0	r Iter	ᇤ	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	Black, Whit		
ဗ္ဗ	urs a	by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: W	hite	
21215-0036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23e or 28e-f ahow Le Medical Exacilirar invest be motified at	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation	16	b. Kind of Business	/Industry	
7	ithin	npie	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of workir DO NOT use retired)				
7	ygier ygier t. I.	S		emaker		Home Ow	ner	
ב	be fill d off	Be	17. Father's Name (First, Middle, Last)  Hoy J. Greene	18. Mother's Name		iden Sumame)		
≅	d Mer nark natic	ို		Jenny W		its or Tour Ctate	Zio Cada)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heath and Menial Hygiene. Department of Heath and Menial Hygiene. Instruments If Imma 27 is marked other than "natural; or Itema 27 is marked other than 27 is marked only in Medical Examination in the Itema 28 is not other traumatic avent, in a Medical Examination in the Itema 28 is not other traumatic avent, in a Medical Examination in the Itema 28 is not other traumatic avent, in a Medical Examination in the Itema 28 is not other traumatic avent.			59 Telegraph Road,		-		
<u>ئ</u>	Heal Heal tam other					c. Location - City or		
<u>o</u> E	ages ant of it: If I		IZOGUNAI 2 CIGINATION 3 CINEMIOVALITOTII STATE	dge Memorial 4-10-	2006 F	lkridge,	MD	
Baltimore,	artm ontar injur	1		22. Name and Address of Facility Sing				
ä	Depa Depa Impo any is	( Y		l Second Ave SW; G1				
	46)		23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or	respiratory arrest		Approximate Interval Between	
70	Physician		0 0	× diserse			Onset and Death	
· *-	/Medical		resulting in death)  Due to (or as a consequence of):	v where				
	Examiner		Sequentially list conditions, b					
(2)	<b>₽</b> / iš	Examiner	if any, leading to immediate cause. Enter Underlying Cause (or as a consequence of): cause. Closease or injury					
1	xecut and al-trar	хап	that initiated events c. resulting in death) Last Due to (or as a consequence of):					
8760,	Attending Physician: The law requires that the death certificate be executed redeath.  redeath.  cator, After this certificete has been signed by the attending physician and yet the funeral director, page 2 should be detached for use as the burial-transit.	icai E	1					
687	ficate p phys	edic	0.					
Box 6	nding nding use a	M	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of del	livery	
m .	res that the death certific igned by the attending p be detached for use as	Physician/Med	in the past 12 months?  1 Ves 2 No. 4 Pregnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		Month	Day Year	
О. О.	t the by th tache	hys	9 □ Unknown					
Š,	es tha	by F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	cco use contribute to	the cause of death?	
D.C	w require been si should I	ted	Alnot fetrillolion, Deep Vein	Unrom Cofe	1 🗆 Yes	2 □ No 3 □ Pr	obably 4 Dunknown	
Records,	hasbe ge 2 sh	Completed	<u> </u>		24a. Was an autopsy	prior to	utopsy findings available completion of cause of	
<u>~</u>	ysician: The is certificate he director, page	Con			performed 1 ☐ Yes 2 X	d? death? No 1 ☐ Yes	25ª No	
<u>i</u>	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)			
$\leq$	Physi this c	ပ္	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpati			e 6 ☐Other (Spe	cify)	
Ë	ding P	io	27. Manner of Dealh 1 SNatural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	Work?	8d. Describe how	injury occurred		
<u>s</u>	ttend death stor:	icat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	9f Location (Street	et and Number or Ru	uml Paula Numbar	
=	after Dirac	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	riest, ractory, once	City or Town, S		TOURS HUMBER,	
	e Hospital of 24 hours at e Funeral Dietely filled i		29a. Certifier 1 Certifying Physicien: To the best of my knowledge, de	ath occurred at the time, date and place, a	nd due to the caus	se(s) and manner as	s stated.	
5)	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director, After th completely filled in by the funeral	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	nvestigation, in my opinion, death occurre	d at the time, date	and place, and due	to the cause(s)	
0	To the within To the Comp	ž	29b. Signature and title of certifier	29c. License number		. Date signed (Mont		
	2400		· (A/1	D 38958	4	16/06		
	$\lambda$		30. Name and address of pe on o completed cause of death (Item 23a) (Typ	D38958 on Heylway SW	0.0	1		
	ν/		Datest Sungh Scully 208 Con	un Meghway SW	Clar !	Jume 1	MD 21061	
	Sta Registr		31. Date tileh (Month, Day, Year) 32 degistrar's Signature	and the same of th				
A	ricgisti	ul .	APR 1 2006   Lines & A					

#### Please Type or Print in Black Indelible Ink

acKey, Aaron	State 1- For State Registrar	of Maryland / Depa Ce		Health an			200 eg. No.	16 1115
Phŷsician/ ledical Examine	Decedent's Name (First, Middle,Last	MACKEY				2. Date of Dea Month April 4, 20	Day Year	3. Time of Death 8:30
	4a. Facility Name (if not institution, give University of Maryland Med	street and number)		City, Town, or Baltimore	Location of Death		4c. County of I	1
Funeral Director	5. Social Security Number 6. Set 218 · 19 · 990 2 1 1 CC Usual Residence of Decedent		last birthday) Yrs.	If Under 1 Year Months Day		1	1	Birthplace (State or Foreig Country)
Maryland 28a-f show any Lat once, ector	10a. State 10b. County		Town or Location					10d. Inside City Limits 1
the Maryland a or 28a-f sh lifted at once	10e. Street and Number  3325 ELBERT		1	10f. Zip Code	29	1	0g. Citizen of What	•
s after death with real", or items 23. niner must be not by Funeral	11. Marital Status 1  W Never Married 2 Married 3 Widowed 4 Divorced		If Yes	Decedent of Hi , specify Cuba les 2 <b>K</b> No	spanic Origin? ( S n, Mexican, Puerto	Rican, etc.)	14. Race - A White, e	American Indian, Black, etc. 3 LACK
21215-0036 uld be filed within 72 hour Mental Hygiene. marked other than "natu c event, the Medical Exan	Elementary/Secondary (0-12)  II IH GRADE  17. Father's Name (First, Middle, Last)	College (1-4 or 5+)  N / A	most of working life. DO NOT use reti			e (First, Middle, I	EDUCA Maiden Surname)	MON
MD 21215-0036 d 2 should be filed within 7 Ith and Mental Hygiene. n 27 is marked other than numatic event, the Medical To Be Comple	MACEO PRICE 19a. Informant's Name/Relationship (Ty	JR (pe, Print)		ddress (Stre		Rural Route Nur	MACICEY mber, City or Town,	State, Zip Code)
ore, MD ss I and 2 sh of Health and If item 27 is her traumat	LORRAINE M. MAC 20a. Method of Disposition 1 Burial 2 Cremation 3		3325 E Place of Disposition crematory or other	on (Name of ce	emetery,	Date	21229 20c. Location - Ci	
Baltimore, permit. Pages I at Department of He. Important: If ite injury or other tr	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licen		ZEENMOW 22. Nar VAUG	ne and Addres		FUNERA1	BALTIMOR SERVICE	
Physician /Medical Examiner		ications that caused the death ch line. Gunshot Wound of He Due to (or as a consequence	n. Do not enter the	mode of dying	, such as cardiac o	or respiratory arr	est, shock, or heart	Approximate Interva Between Onset and Death
ted Insit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence						
0, e be executed ysician and burial - transit		AMENDED item#1,	perME,g855,	5/1/200	6 TT			
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be deached for use as the by endical Certification: To Be Completed by Physician/Me		23c. If yes, outcome of pred 1 Live birth 4 Pregnant at time of d	2 Fetal	death 3 r (Specify)	Ectopic pregn	ancy	23d. Date of de Month	elivery Day Year
P.O. I res that the signed by the be detached		contributing to death but not	resulting in the und	derlying cause	given in Part I.			te to the cause of death?  Probably 4 Unknown
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death.  To the Funeral Director: After this certificate has been signed by completely filled in by the funeral director, page 2 should be detailed in a few forms of the forms of the forms of the forms of the forms of the forms of the few few feetal Certification: To Be Completed by Feetal Certification:						24a. Was autop perfo 1 ✓ Yes	osy prio rmed? dea	re autopsy findings availabler to completion of cause of oth? Yes 2 No
of Vital B Physician: ter this certifi eral director,	25. Was case referred to medical examiner?	ospital: 1  Inpatient 2 28a. Date of Injury	ER/Outpatient 28b. Time of Inju	3 00A	e of Death (Check Other Mursi ury at Work?	ng Home 5	Residence 6 how injury occurred	Other:
Division o spital or Attending tours after death. neral Director: Afte filled in by the fune Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not	(Month Day Year) Apr 3, 2006	20:20	1	Yes 2 V No	Subject sho	ot	or Rural Route Number, City
Div e Hospital on 124 hours aff e Funeral Di etely filled in		(Specify) Sidewalk an: To the best of my knowled	-			d due to the cau	ssman St., Bal se(s) and manner as	s started.
To the Ho within 24 To the Fu Completel	29b. Sonature and title of certifier	On the basis of examination and manner stated.	and/or investigatio	29c. Licen		at the time, date	29d Date signed	(Month, Day, Year)
3	30 Name and address of person who of Laron Locke MD. Assist	completed cause of death (Iter cant Medical Examiner			more, MD 212	201	April 5, 2006	
State Registra	31. Date filed (Month, Day, Year)	3 Registrar's Signal			more, MID 217			

DHMH 17 Rev 1/2001 OCME 10/2003

ORIGINAL

06-02355	
Marshall,	Mary

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

moritani, retary		1- For State Registrar	te or Maryland		rtificate of				Re	eg No 20	06	1115
Physicia	an/	Decedent's Name (First, Middle,						1	Date of Deat Month_	Day Year		3. Time of Death 18:51
edical Exami		4a. Facility Name (if not institution,	-		4	b. City, Town,	or Location of		April 5, 20	4c. County o		10.51
∠' ''		202 New Mark Espland				Rockville	an liftinda	04U D	Date of Biol	Montgon		wlose (State or Foreign
Funeral Director		5. Social Security Number 129-24-4193	. Sex 7. Ag	76	ast birthday) Yrs.	If Under 1 Ye  Months Da	ays Hours	Min.		18, <del>1927</del>	Cour	place (State or Foreigr htry) entina
any		Usual Residence of Decedent 10a. State 10b. County		10c City	Town or Location	on						10d. Inside City Limits
<b>3</b>		Maryland Montgo	amern		Rockv							1 X Yes 2 No
arylan 8a-f sl at onc	Director	10e. Street and Number	Sinci y	ł	ROCKV	10f. Zip Code			10	Og Citizen of Wh	at Count	ry?
i with the Maryland ms 23a or 28a-f show be notified at once.	<u> </u>	202 New Mark E	splanade				20850			United	Stat	es
ite ite	Funeral	11. Marital Status 1 Never Married 2 Mar	12. Was Decedent ried Armed Forces 1 Yes 2	t Ever in U. ?  X  No	.S. 13. Was	s Decedent of Fes, specify Cub				14. Race White		an Indian, Black,
after da	by Fi	3 X Widowed 4 Divor	ced If Yes, Give Year or Dates:	140	1	Yes 2X	No specify:			Specify:	Wh	ite
1215-0036 d be filed within 72 hours afte fental Hygiene. arked other than "natural", event, the Medical Examiner	edt	15. Decedent's Education (Specif			16a. Decedent during				done	16b. Kind of Bus	iness/In	dustry
36 tin 72 than "dical	plet	Elementary/Secondary (0-12)	College (1-4 or	5+)		vorking life. DO C Activ:		tired)		Educa	tion	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Completed	17. Father's Name (First, Middle, L	1		CIVIC	ACTIV.	1	s Name (Fi	rst, Middle, N	Maiden Surname)	LIOII	
21215 uld be file Mental H marked o	Be (	Austin Deane					Ada	Brow	ner			
	ပ	19a. Informant's Name/Relationshi								nber, City or Tow		
re, MD stand 2 shound from 27 is in If item 27 is in item		Christopher D. 1 20a. Method of Disposition	Marshall/So		I War: Place of Disposi		-	-	ort, N	ew York 20c. Location -		
imore, MD 2  Pages I and 2 shou nent of Health and N lant: If item 27 is r or other traumatic		1 Burial 2 X Cremation	3 Removal from St	tate	crematory or oth	er place)		Ар	ril 2006			Maryland
Baltimore, permit. Pages I an Department of Her Important: If ite injury or other tr		4 Donation 5 Other Spe 21. Signature of Funeral Service Li		MOII	tgomery Ci			10,	2006			
Ba perm Depr		anguelle Bay	w <del>-</del>	M01	1305 Rob	ert A. Pu West Mor	mphrey ntgomery	Funera Avenu	ıl Home we, Rock	/Rockville ville, Ma	e, Ind rylan	c. d 20850–2805
Physician		23a. Part I. Enter the disease, or confailure. List only one cause o		the death								Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease	a. Head Injuries									Death
<i>J</i>		or condition resulting in death)	Due to (or as a cons	sequence o	of):							
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	sequence o	of):							
7	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	c. Due to (or as a cons	equence	of).							
cuted		events resulting in death) Last	d.		-17.							
eve	Medical	UNPENDED	X AMENDED #8	3 per	fh g854	4 4-18-	06 <b>v</b> t					
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Her this certificate has been signed by the attending physic tely filled in by the funeral director, page 2 should be detached for use as the bur	Physician/Me	IF FEMALE: 23b, Was decedent pregnant in the past 12 months?  1 Yes 2 ✓ No 9 Unkr	23c. If yes, outco 1 Live birth 4 Pregnant a 9 Unknown		2 Fe	tal death :	3 Ectopic	pregnancy	,	23d Date of delivery Month Day		
D. B trthe de by the		Part II. Other significant condition		th but not i	resulting in the u	ınderlying caus	e given in Pa	art I.	23e Did to	obacco use contri	bute to th	ne cause of death?
P.O. res that the signed by be detac	d by								1 Yes	s 2 🗸 No 3	Proba	ably 4 Unknown
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b.	Completed								24a. Was autop	sy p		opsy findings available impletion of cause of
Rec The la	Som								1 Yes		Yes	2 No
tal Recitian: The L	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpati		] ED/O. 4- 454		oce of Death (			Residence 6	Other	Conn
of Vid Physic er this	2	1 Yes 2 No 27. Manner of Death	28a Date of Ini	urv	ER/Outpatient 28b. Time of I		njury at Work			how injury occurr		Scelle
ion of tending Pleath cor: After the funera	tion	1 Natural 5 Pendi	ng FOUND: Day,	Year)	FOUND: 18:14		Yes 2	No Pr	obable fa	II		
Division  To the Hospital or Attendit within 24 hours after death To the Funeral Director: /	Certification:	3 Suicide 6 Could	not be		ome, farm, stree	et, factory, offic	e building, etc		or Town, S			al Route Number, City
Di To the Hospital - within 24 hours a To the Funeral I		Torreor oray	ysician: To the best of mainer: On the basis of exa	ny knowled	dge, death occur			ace, and du	e to the caus	se(s) and manner	as starte	ed.
To the within 2 To the complet	Medical	29b Signature and title of certifier	and manner stated				ense number	0_ 0. (	.5, 44.0	29d. Date sign		
	6	Carol	Har	ele	ev		C.M.E.			April 6, 200		· - • • • • • • • • • • • • • • • • • •
16		30. Name and address of person v	who completed cause of istant Medical Exa		n 23a) 111 Penn S	Street. Balti	more. MD	21201				
•	tate		Registr									

DHMH 17 Rev 1/2001 OCME 10/2003

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** Month 2:00 A. M APRIL 9, 2006 MARGARET M. OBERLE /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner GILCHRIST CENTER TOWSON BALTIMORE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10/14/1923 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 ☐ M 2 ☐ XF MARYLAND Director 82 219-16-<u>3311</u> Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-1 ehow Examiner must be notified at 1 Yes 2 No Director BALTIMORE TOWSON MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Iteme 23a 1607 MUSSULA ROAD 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 "natural", or 1 ☐ Yes 2 💢 No Specify: δ Specify. WHITE 3 Widowed 4 Divorced Completed injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) is marked other than College (1-4or 5+) Margare SECRETARY BGE 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fit and Mental F JOSEPH OBERLE ANNA KNOERR ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If Item 27 I 18316 UPPER BECKLEYSVILLE RD. HAMPSTEAD. MD 21074 HEATHER KUCHTA/NIECE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. MOST HOLY REDEEMER 4/11/2006 BALTIMORE, MD

22. Name an Address of Facility THE JOHNSON FUNERAL HOME, P.A. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Segvice Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 nt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Years Congestive /Medical Due to (or as a consequence of): Examiner Years Stenosi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? 201No 1 Yes 2 No After this certification funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSP, ( Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death.

I Director: A d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10061199 MD Mpv.1, 9. 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Charles St Juson Black 6601 Touson MD 21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 340 PM Month Da **Physician** :LIZABETH 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b City Town, or Location of Death **Examiner** ,U/A BALTIMORE JOHNS HOPKINS CARE CENTER If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Country) MARYIAND 1□M 2**Ø**F Days Hours 216 07 2230 Yrs. JULI Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or 28a-f show the Medical Examiner must be notified at MD n/a 1 XYes 2 □ No Baltimore Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 202 S. Fagley Street 238 21224 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 232 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 9 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 Widowed 4 Divorced "naturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Lebow Clothier Seamstress 9th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H ant: If item 27 is marked ott Adam Seitz traumatic Lena Gunther 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 258 Foster Knoll Dr., Joppatown MD 21085 Location Oily or Town, State permit. Pages 1 and 3 Department of Health Important: If item 27 any injury or other tr once. Janice Grabowski 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State 4/14/2006 Baltimore, MD Oaklawn 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. FH 21. Signature of Funeral Service L 263 S. Conkling St. Baltimore, MD 21224 nare anne 23a. Part1. Enter the disease, or complete ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only doc cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ARRHY THMIA MINUTES Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner and I-transit The law requires that the death certificate be executed FAILURE 及 (88760, 水 that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, à Dementin 1 Yes 2 No 3 Probably 4 Unknown Completed HUPER TENSION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy CHRONIC OBSTRUCTIVE PHUZONARY DISTAIR 1 ☐ Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 04283 APRIL 10 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 HOPK 103 W CIRCLE

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MO

BALTIONDRE

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: To the Front after death.

To the Funerel Director: All

the State

29b. Signature and title of certifier RENU GUPTA

29c. License number

1 🔀 Certifying Physician: To the best of my knowledge dash becomed at the time date and place and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RENU GUPTA GOOD SAMARITAN HOSPITAL, 5601 LOCH RAVEN BOULEVARD,

04/ 2006 BAUTIMORE, MD

31. Date fifed (Month, Day, Year)

29a. Certifier

(Check only

cal

1 2006

Registrar

			1 - For State Registrar	State of Marylar		artment of H			Reg. No. UU	6 1116	0
Ė	Physicia /Medic		Decedent's Name (First, Middle, Last Ce	) ecile Marie Pi	ickart			2. Date of De Month April	5, <sup>Day</sup> 2006	Year 9.05 I	
	Examin		4a. Facility Name (If not institution, give Home; 221 Stony Ru  5. Social Security Number 6. Se	ın Lane Apt.		4b. City, Town, or Balt	Location of Death imore If Under 24 Hrs.			N/A	oreian
	Funeral Director			X ☐ M <b>%</b> (¬, Age (,,,, y) s.	51 Yrs.	Months Days	Hours Min.	May 6,	y, Year) 1954	Maryland	
	Maryland e-f ehow	ctor	MD 10b. County N/A	_	ity, Town or Lo Baltimo						
	th with the 23s or 28	Funeral Director	10e. Street and Number 221 Stony Run Lane	Apt. El		10f. Zip Code 21	210		U.S.A.		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or Items 23s or 28s-f show any injury or other treumatic event, Ire Medical Examinar must be notified at ance.	þ	11. Marital Status  XX Never Married 2  Married 3  Widowed 4  Divorced	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 XXo If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cubai 1 ☐ Yes 2▼XNo	spanic Origin? (S n, Mexican, Puert Specity:	pecify Yes or No o Rican, etc.)	k, White, etc.		
Maryland 21215-0036	d within 72 ho giene. In then "natur	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12+	cation de completed) College (t-4or 5+) 5+	(Give	dent's Usual Occupa kind of work done d DO NOT use retired, ochemist	luring most of wor	rking			
/land	uld be filed Mental Hyg irked other itic event,	To Be C	17. Father's Name (First, Middle, Last) Stanley J. Pic	ckart		18. Mother's Name (First, Middle, Louise Salvio			99)		
e, Mary	and 2 sho salth and I n 27 ie mu		19a. Informant's Name/Relationship (T	Partner	221	Stony Run	Lane A		Balto,	MD 21210	
Baltimore,	Pages 1 ment of H ant: If iter lury or oth		20a. Method of Disposition  1 □ Burial 2 X X remation 3 □ 4 □ Donation 5 □ Other (Specify,	Me	etro Cr	sition (Name of matory or other place ematory	4/8	3/2006	Death Day Pear Day Day Day Day Day Day Day Day Day Day		
Balt	Depart Depart Import any in		21. Signature of Funeral Service Licen	mount					,		
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or compshock, or heart failure. List only commediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. METASTA  Due to (or as a conse	quence of):	KIDNEY			11631,	Interval Betwee	ath .
Box 68760, <	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical Exar	23b. was decedent pregnant	c. Due to (or as a conse d	nancy	Dectopic pregnancy					ar
P.O. B	the deal by the att	hysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	4☐ Pregnant at time of 9☐ Unknown		Other (specify)					
	w requires that been signed should be de	by	Part II. Other significent conditions co	ontributing to death but not re	sulting in the u	nderlying cause give	en in Part I.		\		
Vital Records,		Completed						perfe	psy ormed?	prior to completion of aus death?	ailable se of
Vita	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 [	☐ ER/Outpatier	nt 3 DOA Oth		ath (Check only		er (Specify)	
ion of	ding After fune		27. Manne   f Death 1		28b. Time o Injury	f 28c. Injury Work					
Division	i Dir e	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st cify)	reet, factory, office		28f. Location ( City or To	(Street and Numb wn, State)	per or Rural Route Numbe	ir,
	he Hospitel or in 24 hours afte he Funeral Dir pletely filled in	edical	(Check only 2 Medical Example)		pinion, death occ		, date and place,	and due to the cause(s)			
	To the within 2 To the complet	Σ	296. Signature and title of certifier			Doc Licens		6			
	6		30. Name and address of person who a ROBEILTO PILL JO	completed cause of death (Ite	om 23a) (Type,	Print)	TER 165	TO ORLE	thus st.	BALTIHORE 1	MD
	St Regist	ate rar	31. Date filed (Month, Day, Year) APR 1 1 20	37 Registrar's Sign	nature	entil					

			State of Marylar				-		gible.	
			1 - For State Registrar		rtificate of Dea		_	Reg. No.	106	11161
	Dhysisia		Decedent's Name (First, Middle, Last)			1	2. Date of Dea		Year	3. Time of Death
	Physicia /Medic		Samuel McCardell Poist	:			pril (	6. 20	06	5:30 PM M
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Locati	ion of Death			unty of Death	
	Funeral			i. last birthday)	Parkville If Under 1 Year If Under 1 Year Hou	nder 24 Hrs.	B. Date of Birt	h	9. Birth	place (State or Foreign
ع الح	Director		216-44-6700 1 1 ★M 2 F 92 Usual Residence of Decedent	Yrs.	Months Days Hou		ember (		3 Mar	yland
SIJ pla	WOM			ity, Town or Lo	peation					10d. Inside City Limits
Mar V	Sa-f st	ctor	Maryland Baltimore Pa	rkville	е					1 ☐ Yes 2 No
death with the Maryland	it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Exacting must be notified at	Funeral Director	10e. Street and Number  8800 Walther Blvd.		10f. Zip Code <b>21234</b>			-	of What Cou	of America
+ 0 00.00000000000000000000000000000000	ms 23	eral	11. Marital Status 12. Was Decedent Ever in U	J.S. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mex	Origin? (Spec			Race - Ameri	ican Indian,
36 gfg	or Ite		Amed Forces?  1 Never Married 2 Married  1 Yes 2 No  1 Yes, Give TILITT		IT Yes, specify Cuban, Mex 1 ☐ Yes 2 🛣 No Spec		ican, etc.)		Black, White,	
T	itural,	ed by	3 XWidowed 4 □ Divorced Year or Dates: WWII  15. Decedent's Education		dent's Usual Occupation				of Business/Ir	ite
1215 within 72	an "na Medic	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done during r DO NOT use retired)	most of working	7	TOD. KIITO C	1 2 2 3 11 0 3 2 11	iousily
700	her th		12 0	Chie	f Inspector				Custo	ms
and E	Mental H arked otl atic even	) Be	17. Father's Name (First, Middle, Last)  Joseph D. Poist			other's Name (			name)	
ALM ULL Maryland	and Mental Hyglene. Is marked other than aumatic event, the Mr	P	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Nu				wn, State, Zi	ip Code)
J. W.	of Health a		Mrs. Barbara B. Barrow (Niece	208 1	Reservoir Ro	ad, Per	ryv111	e, Ma	ry1and	21903
	If item or oth		20a Method of Disposition 20b. i	Place of Dispo	esition (Name of matory or other place)	Da			on - City or T	
Baltimor	rtmer rtant njury	Į	*4 □ Donation 5 ♥ Other (Specify Entombment Dr 21. Significe of Funeral Service Linessee	ruid Ri	dge Mausoleur 2. Name and Address of Fa					M aryland
Balti	lmpo any i	1	Joseph Kellner mo 033	2.79	728 Liberty	POLI				Directors, In
a	*		23a. Ph. 1. Enter the discrete, or complications that caused the dea shock, or heart failure. List only one cause on each line.		er the mode of dying, such	as cardiac or	respiratory ar	rest,	, maryı	Approximate Interval Between
Ph	ysician -		Immediate Cause (Final disease or condition	20						Onset and Death
	ledical aminer		Due to (or as a consec	quence of):						7000
40		e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consec	quence of):						
\$ beau	sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Leseese or injury that initiated events						- 29	
760, 1e be execu	cian a	EX	resulting in death) Last Due to (or as a consec	quence of):						
	~ 00	dicai	d							
Mu.    Records, P.O. Box 68	by the attending physician tached for use as the buria	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregn		3			23d.	Date of deliv	rery
S. B.	he atte ed for	sicia	in the past 12 months?  1 Yes 2 No  1 Ves 2 No		Ectopic pregnancy Other (specify)				Month	Day Year
P.O. hat the d	ed by the detached		9 Unknown  Part II. Other significant conditions contributing to death but not res	sulting in the u	ndarhving causa gwan in Pr	art I	23a Did to	bacco use c	contribute to 1	the cause of death?
Records,	pe pe	d by	BPH. Hematica	Jaking in the di	nderlying cadde given in the	arci.	1 🗆 Y	1/		bably 4 Unknown
COL WE FIRST	s beer	ompieted					24a. Was		b. Were auto	opsy findings available
<b>R</b> 14 14 14 14 14 14 14 14 14 14 14 14 14	ficate has	om					autop perfor 1 Yes	med?	prior to co death? 1 \( \sum \text{Yes}	ompletion of cause of
of Vital Physician: T		BeC	25. Was case referred to medical examiner?			lace of Death (	<u> </u>			
P. O. Y.	this di	- T		ER/Outpatien		Nursing Home	5 🗌 Resid		- ' '	fy)
7 6	: After the function	ation	27. Manner of Deliff  1 Natural 5 Pending 2 Accident Accident Accident Solution (Month, Day Year)	Injury	28c. Injury at Work?  M 1 Tyes 2		d. Describe ii	OW injury OC	Juliou	
Division Tor Attending	rector: Al	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At h building, etc. (Special Country)	nome, farm, str	eet, factory, office	28	f. Location (S City or Tow		ımber or Rur	al Route Number,
oital o	ins all					-				in the state of th
Division To the Hospital or Attending	within 24 hours after death. To the Funeral Director: At completely filled in by the fu	dical	29a. Certifier  (Check only one)  (Check only one)  (Check only one)  (Check only one)	owledge, death ation and/or inv	n occurred at the time, date vestigation, in my opinion,	e and place, an death occurred	d due to the d at the time, d	ause(s) and late and plac	manner as s ce, and due t	stated. to the cause(s)
To the	To the	Me	29b. Signature and title of certifier		29c. License numb	per		29d. Date sig	gned (Month,	Day, Year)
			1/200		2131	12		Apr	175	n 2006
11	()		30. Name and address of berson who completed cause of death (Iter			P	Ev. 14	·M	) 21	234
	Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signs		100 1000	000		1,4	, -,	U I
	Registra		APR 1 1 2006	South						

Physi /Me Exan

		State	of Maryland	l <b>ack In</b> L/Depa	artment	of H	lealth	and M	lental Hyd	niene		
1 - State Registrar		Otate c	71 Wai yiana		rtificate					leg. No.	006	11162
Decedent's Na	me (First, Middle SHIF			PI	ERLMAN	1			2. Date of Dea	Day	Year 200	3. Time of Death 6 957 A M
	(If not institution HOSPIT	n, give street and nu AL	m <i>ber)</i>		4b. City, T		Location			4c. Co	unty of Dea	nth N/A
5. Social Security 217-50		6. Sex 1 □ M 2 ☑ F	7. Age (In yrs. la: 58		tf Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth Month Day AUG. 7, 1	947	9. Bir	thplace (State or Foreign ountry)
Usual Residence	of Decedent		10c. City,	Town or Lo	cation							10d. toside City Limits
MD		N/A	В	ALTIMO	ORE							1 ∑Yes 2 ☐ No
10e. Street and 6107	lumber IST AVE	NUE			10f. Zip	Code	2:	1215		10g. Citizer	of What Co	ountry? USA
	arried 2∭X Mar	ned 1 ☐ Yes	. 2 <b>X</b> No ive		Was Decede If Yes, speci	rfy Cuba	ispanic Oi an, Mexica Specify	in, Puerto	ecify Yes or No- Rican, etc.)		Race - Ame Black, White ecify:	erican tndian, te, etc. WHITE
(S)	15. Deceden	it's Education st grade completed		(Give	dent's Usual kind of work DO NOT use	k done d	during mo	st of work	ing		of Business	/industry
17. Father's Nan	a /First Middle	5+		IEA	CHER		10 Moth	oria Name	e (First, Middle,		ATION	
JACOB	a (First, Middle,	Last/	J	ANOWSI	ΚI			OBRA	a (First, Middie,	Maiden Su	maine)	HORN
19a. Informant's		hip <i>(Type, Print)</i> / HUSBAN	D		-				ALTIMORE			Zip Code)
		3 □Removal from	State cer	metery, crei	osition (Name matory or oti I SRAEL	her plac			09/2006		tion - City or EDALE	Town, State
21. Signature of	Funeral Syrvice	Licensee			2. Name and			30	L LEVIN			., INC.
shock, or Immediate Caps disease or cond	art falle e. List e (Final ition	complications that only one cause on	each line.		er the mode	·	•		or respiratory ar	rest,		Approximate Intervat Between Onset and Death / 2 Lows
resulting in deal		b	(or as a conseque	ence of):								10 years
Sequentially list if any, leading to cause. Enter Ui Cause (Disease that initiated everesulting in deat	derlying or injury nts	<b>S</b> a	(or as a conseque	THERM	apy							15 plus yans
	,	d	Or as a conseque		ER							15 years
tF FEMALE: 23b. Was deced in the past 1 ☐ Yes 9 ☐ Unkno	12 months? 2 ☑ No	1 Live	itcome of pregnant birth 2   Fetal on nant at time of dea nown	death 3□	Ectopic pre		,			230	I. Date of de Month	olivery Day Year
		ons contributing to c		-		-	en in Part	i.			_	o the cause of death?
D	IABIZTE	s WIZL	itus						24a. Was autop perfo	an 2 sy med?	death?	utopsy findings available completion of cause of
25. Was case re	ferred to medica	t			-		26 Plan	e of Deat		212No	1 🗆 Ye	s 2 No
examiner?		Hospitat:	Inpatient 2 1	R/Outpatier	nt 3 DO	A Oth	or		me 5 ☐ Resid		Other (Spe	ecify)
27. Manner of D  1 Naturat 2 Acciden	5 Pendir	28a. Date (Mor		28b. Time o Injury		Bc. Injun	y at		28d. Describe h			
3 ☐ Suicide	6 ☐ Could	not be	e of Injury - At hom	ne, farm, str	reet, factory				28f. Location /S	treet and N	lumber or A	tural Route Number,

To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

State

Medicai Cer

31. Date filed (Month, Day, Year) 2006 APR 1

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



ROBERT

29a. Certifier (Check only one)

1 PCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number P30377

AVE

29d. Date signed (Month, Day, Year)

BALT NW 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** A M 2006 8:02 April Pavlos Papapavlou /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Owings Mills Baltimore 4839 Wainwright Circle If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, Sept 22, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 □ F 1935 Greece Director 463-90-9633 70 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-1 show treumatic event, the Medical Examinar maint be notified at 1 ☐ Yes 2 ☐ No Director Owings Mills Baltimore 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number Canada 4839 Wainwright Circle 21117 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "naturel", or ite 1 ☐ Yes 2 ☐**X**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Chef Restaurant 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Maria Georgas Antonios Papapavlou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4839 Wainwright Circle; Owings Mills, MD 21117 wife other Anthi Papapaylou 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. George Greek
Orthodox Church Cem. Date unk, 20c. Location - City or Town, State 20a. Method of Disposition 1 NBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Georg ŏ Department Important: If eny Injury or once. Malona, Rhodes, Greece 21. Signature of Fureran Service License 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home MYOCARDIAL INFARCTION

Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical HEART DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner une as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 0 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one 1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 A esidence 6 Other (Specify) ဥ this 28c. Injury at Work? 28d. Discribe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 24 hours after death The Funsiel Director: / 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10063145 cause of death (Item 23a) (Type, Print) OESLER RD ESAI ND

DHMH 17 Rev 1/2001

State

Registrar

egistrar's Signature

2006

			1 - For State Registrar	State of Ma	ryland		artmen <i>tificat</i>			and Mo		giene Neg. No.	006		116	51.
	Physici	an	1. Decedent's Name (First, Middle, Last	STEDMA	2	ROC	36 R	75			2. Date of Dea Month	Day	7 <sup>Ye</sup>	ar O6	3. Time of D	
	/Medic		4a. Facility Name (If not institution, give	street and number)			4b. City,	Town, or	Location o	of Death			County of E	eath		
			Homewood at Crumla		//		Il Under		rick	24 Hes 1			Fred			
в	Funeral Director		5. Social Security Number 6. Se 060-05-8667		( <i>In yr</i> s. <i>I</i> a: 95	st birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birtl (Month, Day Dec. 11	Year)	10	Country	ce (State or ) y) ginia	Foreign
	p ,		Usual Residence of Decedent  10a, State 10b, County		10c City	Town or Lo	oction							100	d. Inside City	Limite
	Maryla -f ehov	to	10a. State 10b. County  Maryland Frederic		roc. ony,		ederi	ck						100	1 Tyes 2	
	r 28a	irec	10e. Street and Number				10f. Zip	Code				10g. Citiz	en ol Wha	Countr	y?	
	23a o	a D	7408 Round Hill F	Road				217	'02			Uni	ted S	tate	S	
98	72 hours after death with the Maryland natural', or items 23a or 28a-f ehow alsea Examirantmust be inclified at	y Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Et Armed Forces? 1 Yes 2 X No If Yes, Give			Vas Deced f Yes, spec l ☐ Yes			gin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)		4. Race - A Black, V Specify:	Vhite, et	c.	
8	hours 'ural',	d b	3 🖾 Widowed 4 Divorced	Year or Dates:		16a. Deced	lantin Linux	1 Occupa	tion				id of Busine	Whi		
15	in 72	Completed by	15. Decedent's Edu (Specify only highest grad	de completed)		(Give	kind of wo DO NOT us	rk done d se retired)	ition luring most )	t of workin	ng	IBD. KI	id of Busine	ess/indu	istry	
212	d with giene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+	-)	Opera:	tor &	oth	er po	siti	ons	Te1	ephon	e Co	mpany	
Maryland 21215-0036	uld be file fental Hyg rked othe	To Be C	17. Father's Name (First, Middle, Last) Robert Stedman								(First, Middle, Frankli		Sumame)			
	nd 2 should be alth and M 27 ie mai		19a. Informant's Name/Relationship (T) Patricia A. Willia		nter		_				Route Numbe					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or items 23s or 28s-f show with Injury or other traumatic event, the Medical Examinational Examination once.		20a. Method of Disposition  1 X Burial 2 Cremation 3 4 Donation 5 Other (Specify)		20b. Pla cer Par	netery, cren klawn	natory or o Memo	ne of ther place rial	9)   A	April 2006			cation · City ville		n, State iry1ano	d
Balti	permit. Depertm Importa eny Inju		4 Donation 5 Other (Specify)  2006  21. Signature of Funeral Service Licensee  M00198  Park  22. Name and Address of Facility Robert A. Pumphrey 7557 Wisconsin Ave., Bether											Chas	la-Cher se, Inc 501	
	Physician		23a. Part 1. Enter the disease, or comp shock, or heart lailure. List only o Immediate Cause (Final disease or condition resulting in death)	aPNELL	-MO1	Do not ento								li d	Approximate nterval Between Driset and De	en ath
	/Medical Examiner			Due to (or as a	RA	TION	١ ز	DYS	PHA	916	+					
	uted d ansit	mlne	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a		_										
8760,	ate be executed hysicien and the burial-transit	dical Examin	resulting in death) Last	Due to (or as a	conseque	ence of):										
687	certificate Iding phys	edic		d												
.O. Box	atter for u	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal	death 3	Ectopic pr Other (sp					2	3d. Date of Month			ear .
<u>α</u>	equires that the deen signed by the nould be detached	1 by Ph	Part II. Other significant conditions co	ntributing to death but	t not result	ting in the ur	nderlying c	ause give	n in Part I.			bacco us		te to the	cause of dea	_
cor	- A to	Completed									24a. Was autop	an		e autops	sy findings av	vailable
Ä	The lav	E O									perfor	med?	deat	h? Yes 2		230 01
ita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?							of Death	Check only o	ne/				
5	S S P	P.	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatien					4 🕒 NU		ne 5 Resid			Specify)		
ono	fune fune	atlon:	27. Manner of Death 1	28a. Date of Injury (Month, Day	Year) 2	28b. Time of Injury	M 2	28c. Injury Work 1 🗀 Y	at :? ∕es 2 🔲 I		8d. Describe h	iow injury	occurred			
Division of Vital Records,	al or Atters a ster des	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injur building, etc.	ry - At hom (Specify)	ne, larm, str	eet, lactory	y, office		2	281. Location (S City or Tow		Number o	r Rural i	Route Numb	er,
	To the Hospital or Attend within 24 hours after death To the Funaral Director: completely filled in by the	edical		rsician: To the best of iner: On the basis of e and manner state	examinatio											
	To the To the Comp	ž	29b. Signature and title of certifier	1A . A				. License		,		29d. Date	signed (N			
	F		10 he hu	- NA				02	1931	6		4	/ 5/		006	
100	(10)		30. Name and address of person who c	MD 65	- C	THON	Print)	104	150 N	26	C. FR	ZED				-1702
2	Sta Registi		31. Date liled (Month, Day, Year) APR 1 1 2006	32. Registra	r's Signali											

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2006 Month **Physician** April 6, 9:20 P M Phyllis M. Ross /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Glen Arm

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
| Months | Days | Hours | Min. | Oct | 25, 1 11630 Glen Arm Road Apt. L43 Baltimore 9. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 💢 F 25, 1922 83 MA Director 019-16-4211 Oct. Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rthan "neturel", or Items 23a or 28a-f shov the Medical Examiner must be nutified at 1 ☐ Yes 2X No Directo Baltimore Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11630 Glen Arm Road Apt. L43 21057 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) George Rowe Winifred Hopps 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 68 Cheryl Hodgins/Daughter 6 Edgarwood Ct. Phoenix, MD 21131 20b. Place of Disposition (Name of cometery, crematory or other place)
Dulaney Valley
Memorial Gardens Date 20c. Location - City or Town, State 20a. Method of Disposition April 10, 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or once. '4 □ Donation 5 □ Other (Specify)

21. 3(gnature of Funeral Service Ucensee 2006 Timonium, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Road Timonium, MD 21093 Bryan W. Clary 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) Atyocarch **Physician** /Medical Due to far as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ certensian 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown cate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 2000 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☐ Mesidence 6 ☐ Other (Specify) ٩ 1 Tes 27. Manner of Death 1 [[Natural 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) within 24 hours after To the Funerel Dirac 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) m 29b. Signature and title of certifier ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who con 640 N 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

2. Date of Death

3. Time of Death

	Fune Direct	
altimore, maryland 21215-0036	smit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland spertment of Haaith and Mental Hygiene. portent: If tem 27 I emziked other then "naturel", or iteme 23a or 28a-1 show by Injury or other treumatic event. the Medical Examiner must be notified at	Co.

1. Decedent's Name (First, Middle, Last)

88 = 8 Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

an Jorel	A (First, Middle, Last)			Ros	5	Month -	Day Year	17586			
er 4a. Facility Name	not institution, give street and			4b. City, Town, or Loca	(1	1	4c. County of Deat	h			
5. Social Security  213 11  Usual Residence of	Number 6. Sex 1 M 2 M 2 M	HOSPITA 7. Age (In yrs. Is F 20	ast birthday) Yrs.		nder 24 Hrs. urs Min.	Date of Birth (Month, Day, Ye	N/A 9. Birtl 0, 1985 M	nplace (State or Fore untry)			
10a. State	10b. County	10c. City	, Town or Loc	ation				10d. Inside City Lim			
g MD.	N/A		BA	LTIMORE				1 Yes 2 □			
MD.  10e. Street and Nu		27.0		10f. Zip Code	0	10g.	. Citizen of What Co	untry?			
1527	GREENDALE RO		140.14	2121		4. V N-	USA 14. Race - Ame	2-2-1-4			
11. Marital Status 1 (XNever Mar 3   Widowed	ried 2 Married 1 1 Yes	Decedent Ever in U.S d Forces? 'es 2 ☑ No i, Give or Dates:		/as Decedent of Hispani Yes, specify Cuban, Me ☐ Yes 2√2 No Spe	ecity:	can, etc.)	Black, White, etc.  Specify: BLACK				
	15. Decedent's Education			ent's Usual Occupation		166	b. Kind of Business/	Industry			
(Spe Elementary/Sec 12TH	cify only highest grade comple ondary (0-12) Colle	ge (1-4or 5+)	life. D	ind of work done during O NOT use retired)	most of working						
	(Fire Added to A col		ATT	ENDANT			&T STAD	IUM			
<u> </u>	(First, Middle, Last)  W. BRANCH			18. 8		First, Middle, Mai L ROSS	den Sumame)				
F-	lame/Relationship (Type, Print)		19b Mailing	Address (Street and N			ity or Town State 2	in Code)			
SHERYL				GREENDA			IMORE, MI				
20a. Method of Dis	•		ace of Dispos	ition (Name of atory or other place)	Dat	te 200	c. Location - City or	Town, State			
	☐ Cremation 3 ☐ Removal f 5 ☐ Other (Specify)	rom State	-		APR.	13,200	6 BALTIN	MORE, MD.			
21. Signature of F	uneral Service Licensee		22 C 7	Name and Address of FALVIN B.							
PRIN	1412 F. PRESTON ST. BAI.TO, MD.  3a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										
Immediate Cause disease or conditi resulting in death)  Sequentially list or if any, leading to it cause. Enter Unicesse to that initiated event resulting in death)	onditions, mmediate priying sinjury s	e to (or as a consequence to (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or a) (or	PACOMA onsequence of):								
IF FEMALE: 23b. Was deceded in the past 12 1  Yes 2		, outcome of pregnan				-	23d. Date of deli	varv			
in the past 12 1 Yes 2 9 Unknown	! months? 4□P	ive birth 2 ☐ Fetal regnant at time of de Inknown		Ectopic pregnancy Other (specify)			Month	Day Year			
à nacle	ficant conditions contributing Mal endo OTherapy	to death but not resul Cardiffs	Iting in the und	derlying cause given in F	Part I.	23e. Did tobac	Did tobacco use contribute to the cause of death				
Completed Completed	otherapy					24a. Was an autopsy perion neg	prior to death?	topsy findings avails completion of cause 2 No			
25. Was case refe		1			Place of Death (	Check only one)	7				
P 1 □ Yes 2	No Hospital:		R/Outpatient		Nursing Home		e 6 ☐Other (Spec	cify)			
27. Manner of Dea	5 Pending investigation 6 Could not be	Month, Day Year)	28b. Time of Injury	28c. Injury at Work?  M 1 Yes	2 🗆 No	d. Describe how i		nt Pouts Number			
4 Homicide		Place of Injury - At hor uilding, etc. (Specify)		ы, таскогу, оптсе	28	City or Town, S	it a <i>nd Number or R</i> u State)	rai moute Number,			
29a. Certifier (Check only one)	Certifying Physicien: To Description of the American Control of the American C	the best of my know he basis of examinati manner stated.	vledge, death on and/or inve	occurred at the time, da estigation, in my opinion	te and place, an , death occurred	d due to the cause at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)			
29b. Signature and	d title of certifier	MA		29c. License num	ber () ()	29d.	Date signed (Monti	n, Day, Year)			

State Registrar ath (Item 23a) Type, Print)

ho completed caus

32. Regionaris Signature

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#4c,10b,perYD State of Maryland TDepartment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2006ar April **Physician** 8, 2:57am M Stephens Marna Ε. /Medical 4b. City, Town, or Location of Death 4c. Coun Frederick 4a. Fecility Name (If not institution, give street and number) Examiner Carroll New Windsor 15425 Barnes Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. Nov. 29, 1921 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2₩F Yrs. 404-26-7488 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Frederick 28a-1 show the Medical Examiner must be notified at 1 Yes 2 No New Windsor Carroll MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò USA 21776 15425 Barnes Road 238 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2√ No If Yes, GiveA Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or itame 11. Marital Status Black, White, etc. hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes ¾☐ No Specify: White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced 'natural', Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 e tiled within al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) is 1 and 2 should be ti. of Health and Mental H Itam 27 is marked oil Bertha Benfield Cain Waycaster 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15425 Barnes Road New Windsor, MD 21776 Mrs. Carol Poff (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ital any injury or ott X□ Burial 2 □ Cremation 3 □ Removal from State Louisville Church Cem. 4/12/06 Gamber, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22</sup>HATCHT<sup>AC</sup>FUNERALY HOME & CHAPEL (Box 195) Sykesville, MD 21784 (410)-795-1400 Buar Haige d. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CAN ASUN /Medical Due to (or as a consequence of): Examiner Due to (obs a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ed by the attending physicien and detached for use as the burial-transit the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has 1 ☐ Yes 2 No or Attending Physician: 26. Place of Death | Check only one 25. Was case referred to medical examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: 27. Manner of Death Atter t Natural 2 Accide 5 Pending investigation 1 Tes 2 No within 24 hours after death. To the Funeral Director: A ☐ Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) tilled in by 4 | Homicide Hospital Sertifying Physician. To the best of my knowledge, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examilies: On the basis of examination and/of investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier icai On the basis of examination completely 29c. License number 29b. Signature and title of certifier D37949 se death (Ite o completed 3a) (Type, Print) en Prox 2herenther 32. Registrar's Sigla Yar 2006 State Registrar

		1-	For Stete Registrer		Sta	te of I	Marylan	•	artmen tificate			and M	lental Hy	giene Reg. No.	006	A contract and the second and the se	68
		_	Decedent's Name	First, Middle	, Last)								2. Date of De	eath Day	Year		of Death
	sician edical			Vernor	1 Georg	ge So	hulthe	eis					April	7	2006		5 A <sup>M</sup>
	miner	4 -	. Facility Name (If n	ot institution	, give street a	nd numb	er)				Location o				ounty of Dea		
			Charle								ville				altimo		
Fune	_		Social Security Nur 212-01-71		6. Sex 1 3 M 2		Age (In yrs. I	ast birthday) Yrs.	If Under Months	Days	If Under:	Min.	8. Date of Bi	rth ay, Year) 0,191	9. Bi	irthplace (State country)	or Foreign
Direct	tor	-	sual Residence of D				90	113.					Aug. 2	0,191	) Ma	ryland	
land ow				Ob. County			10c. City	, Town or Lo	cation				<del> </del>			10d. Inside	City Limits
Mary Fed	בַּ	5	MD	Balti	lmore			Catons	sville	e						1 🗆 Ye	es 2511No
r 28s	1 2	10	e. Street and Numb	er					10f. Zip	Code				10g. Citize	on of What C	ountry?	
h with	Funeral Director	1	715 Mai	den Cl	noice I	ane	CR604			212	228			U	SA		
dead	100	11	. Marital Status			s Decede	ent Ever in U.	S. 13.	Was Deced	ent of His	spanic Original	gin? (Spe	cify Yes or No Rican, etc.)	0- 14	Race - Am Black, Wh	nerican Indian,	
efter of	ų,		1 Never Married	_	ed 1 🔀	Yes 2	□ No		1 ☐ Yes		Specify:	,			Specify: W		
ING 21215-UU36  be filed within 72 hours efter death with the Maryland tal Hygiene.  coher than "natural", or iteme 23a or 28s-1 ehow event, the Medical Evanimar must be notified at	1		3 Widowed 4		Yes	ar or Date	s: 1945-										
72 i	Commisted			<ol><li>Decedent only highes</li></ol>	's Education t grade comp	leted)		16a. Deced	dent's Usua kind of wor DO NOT us	rk done di	uring most	of worki	ng	16b. Kind	of Busines	s/Industry	
within and the than	É		Elementary/Second	lary (0-12)	Col	lege (1-4	or 5+)	Adve				r		Nova	spaper		
The High	2		. Father's Name (F	irst, Middle, I	Last)			71ct v C 1	CIOI				(First, Middle				
Maryiand d 2 should be file th and Mental Hy 17 is marked oth treumatic event	L R B		William	George	Schul	thei	.s				Wi	1hem	ina Scl	hreine	er		
laryiar 2 should be and Menta is marked	-		a. Informant's Nam	e/Relationsh	nip <i>(Type, Pri</i>	nt)		19b. Mailir	ng Address	(Street a	nd Numbe	or or Rura	I Route Numb	er, City or	Town, State,	Zip Code)	
C 2 04 F		7	Virginia	Schu1t	heis	_	Wife	715 N	laider	n Cho	oice	Lane	CR604	Cato	nsvill	e. MD	21228
		20	a. Method of Dispo					lace of Dispo	sition (Nan	ne of			Date			r Town, State	
Baltimor permit. Pages Depertment of Important: if Its			1  Burial 2  4  Donation 5			I from Sta	3(0)	ke Viev	-			4-11	-2006	Sykes	sville	, Mary	land
alt mit. ports y Inju	8	21	I. Signature of Fund	eral Service l	icensee	1//	///	22	Name an	d Addres	s of Facilit	Ste	rling-/ tonsvi	Ashtor	-Schw	ab-Wit:	zke
n 82 = 2	а	1		Mo	£	26			630 1	Edmor	ndson	Ave	nue; Ca	atons	ville,	MD 21	228
		23	3a. Part1. Enter the shock, or heart	disease, or failure. List	complications only one caus	that cau	sed the death	n. Do not ent	er the mod	e of dying	g, such as	cardiac o	or respiratory a	rrest,		Approxim Intervat B	etween
Physicia	an	lm di	nmediate Cause (Fi	nal		Me	tagti	atu	pro	sta	to	(	auce	er		Onset an	d Death
/Medic Examin		re	sulting in death)		("	ue to (or	as a consequ	uence of):	/								
CXAIIIII	ш.	Se	equentially list cond any, leading to imm	Ttions.	b									_			
be at	90	ca C	any, leading to imm luse. Enter Underly ause (Disease or in	ring 🚄		or euc	as a consequ	uence of):									
xecut and Il-tran	Fxaminer	th	at initiated events sulting in death) La	•	С	ue to (or	as a consequ	uence of):								-	
. BOX 68 / 6U, death certificate be executed e attending physicien and of or use as the burial-transit	ie																
68/ ificate g phys	o Pa				0												
BOX 61 leath certific attending p	Physician/Med	IF	FEMALE: 3b. Was decedent p	regnant			me of pregna							23	d. Date of de	elivery	
death death death death	9		in the past 12 m	onths?	4	Pregnan	n 2 ☐ Fetal tat time of de		]Ectopic pr ] Other (sp						Month	Day	Year
	N A	-	9 ☐ Unknown		9L	Unknow	n						1				
# 5 B	3		rt II. Other signific	ant conditio	ns contributir	g to deat	h but not resu	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did	tobacco us	contribute	to the cause o	f death?
Hecords, he law requires t e hes been signe	0								-				10	Yes 2	No 3□F	Probably 4 [	Unknown
BCC lawri es be	Completed												24a. Was	s an	24b. Were a	autopsy finding completion of	s available
The law cete hes page 2 s													perfe 1 ☐ Yes	ormed? _	death? 1 ☐ Ye	,	
VISION OF VITAL Attending Physician: T or death. ector: After this certificet by the funeral director, ps	9	25	. Was case referre	d to medical								of Death	(Check only	one)			
Of V Physic this c	P		1 Yes 2 N	6	Hospita	1 U Inp		ER/Outpatier			4 LINU		me 5 Res			ecify)	
OIO OID OID OID OID OID OID OID OID OID	2	27	. Manner of Death	5 Pending		(Month,	njury Day Year)	28b. Time of Injury		8c. Injury Work			28d. Describe	how injury	occurred		
ISIC Itend Ideath Iten:	å		2 ☐ Accident 3 ☐ Suicide	investig	ot be	Dt4	Jaires Atha		M		′es 2 🗆 I		28f. Location	(Ctroat and	Number or f	Distal Courts No	
- 5-5-5	Certification		4 Homicide	determi	ned 286	building	Injury - At ho , etc. (Specify	nne, iaim, str /)	eet, ractory	, office			City or To	wn, State)	i vumber or r	TOTAL FIGURATE	imber,
spital ours neral	2		Pa. Certifier 1	Certifyin	g Physicien:	To the be	est of my kno	wiedge, deati	n occurred	at the tim	e date an	d place.	and due to the	cause(s) a	nd manner a	as stated	
To the Hospital of within 24 hours at To the Funeral D completely filled is	Medical		(Check only 2 one)	☐ Medical (	Examiner: O	the basi	s of examinat	tion and/or in	vestigation,	, in my op	inion, dea	th occurr	ed at the time,	, date and p	lace, and du	e to the cause	e(s)
To th Veithin To th	2	29	b. Signature and tit	le of certifier			4			. License				29d. Date	signed (Mor	nth, Day, Year,	
				VE	2 as	u	N			/	Dec	20	040	91	7/1	06	
(et 197		30	). Name and address	s of person	who complete	d cause	of death (Item	23a) (Type,	Print)	[her	ue.	ta	040 me	Cil	chi	ulle.	MCP
	State	31	I. Date filed (Month	Day, Year)		32. Reg	istrar's Signa		00.	70						7/2	25
Reg	istrar		API	711	2006	Reg )	as de	430	A S								

			1 - For State Registrar	State of	Marylar	•	artmer rtificat			and M		Reg. No.	UUD	11169
	Physici	an	Decedent's Name (First, Middle, La	ist)							2. Date of De.	Day	Year	3. Time of Death
	/Medic	al	Samuel  4a. Facility Name (If not institution, gire	e street and numb		Sconi			Location of	of Dogsth	4	4	2006 County of Dea	10:45pm <sup>M</sup>
	Examir	er	429 Oak Street	o stroot and nume	<i>(</i> 01)		1	berd		or Death		40.	Harfor	
150	Funeral	- 17		Sex 7.	Age (In yrs.	last birthday)	If Unde	1 Year	If Under		8. Date of Bir	th		rthplace (State or Foreign
	Director		220-20-9601	1 ₹ M 2 □ F	77	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da 8-2-	у, <i>Үваг)</i> 28	0	Md.
	۵ >		Usual Residence of Decedent  10a. State 10b. County		100 Ci	ty, Town or Lo								10d. Inside City Limits
	show	ក		-	100. 01									1 TYPes 2 No
	the N	ect	Md. Harfo	<u>ra</u>		Abero	ieen 10f. Zij	Code				10a Citi	izen of What C	
	with Ba or	ă					101. 21	2100	)]			, og. om	USA	ountry :
	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f show Ira Madical Exaculter must be notified at	by Funeral Director	429 Oak Street	12. Was Decede		J.S. 13.	Was Dece			gin? (Spe	ecify Yes or No Rican, etc.)	-	14. Race - Am	
9	or Ite	F	1 ☐ Never Married 2X Married	Armed Force 1 Tes 2 If Yes, Give	X No		lfYes,spe 1∐Yes		n, Mexicar Specify:		Hican, etc.)		Black, Wh	
933	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Date	es:		1 🗆 1 65	2 <u>A</u> 1 N0	эрвспу.					Black
21215-0036	"natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece (Give	kind of wo	al Occupa	ation <i>during</i> mos I)	t of worki	ng	16b. Ki	ind of Busines:	s/Industry
12	withir sne. than	du	Elementary/Secondary (0-12)	College (1-4	or 5+)		.1 Cle		)			Abe	rdeen E	Proving Groun
0 0	filed withi I Hygiene. other than	ပို	12th grade 17. Father's Name (First, Middle, Las.	')					18. Mothe	er's Name	(First, Middle,	Maiden	Sumame)	
au	should be ind Mental I	To Be	Samuel		Sconi	ion, Sr			El.	la			Chris	sty
Maryland	shou and M s mar	-	19a. Informant's Name/Relationship	Туре, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	l Route Numbe	er, City o	r Town, State,	Zip Code)
	and 2 ealth a n 27 ls		Edna Sconion	Wi	fe					Abero	deen, M	đ.	21001	
ore	of He		20a. Method of Disposition 1√2 Burial 2 ☐ Cremation 3 [	Bemoval from St	20b. l	Place of Dispo cometery, cres	sition (Na. matory or c	ne of other place	θ)	C	ate	20c. Lo	cation - City o	r Town, State
Ĕ	Pages ment of ant: If It ury or o		4 Donation 5 ☐ Other (Speci	fy)		. Jame	es Cer	neter	<b>C</b> Y	4-8-	-06	Hav	re De (	Grace, Md.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. I'm Medical Exerciter must be notified at once.		21. Signature of Funeral Service Lice	nsee	<u>ب</u>				is of Facility I. Eas	-	Bal 1101 1	timo: E. N	re, Md. orth Av	21202 ve.
7,092	thet the death certificate be executed  Wedpine attending physicien and detached for use as the burial transit	dicat Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Oue to (cr		(uanda of):	EART	F	AICG	IRE				Interval Between Onset and Death
.O. Box (	Attending Physicien: The law requires thet the death certifica rideath. ctor: Alter this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as it by the funeral director.	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2∏Feta ntattime of o	al death 3	⊒Ectopic p ⊒ Other (s <sub>f</sub>						23d. Date of de Month	olivery Day Year
o.	res thet tigned by	y Ph	Part II. Other significant conditions	contributing to dear	th but not res	sulting in the u	nderlying	ause give	en in Part I		23e. Did te	obacco u	ise contribute	to the cause of death?
Records,	quire; m sig uld bi		CIRRHOSIS OF	= LIVER							10	res 2	ØN0 3□F	robably 4 Unknown
000	aw requir s been si 2 should I	Completed	ATRIAL FIBRIC	LATION							24a. Was		24b. Were a	utopsy findings available
æ	The I	E	RENAL FAIL								autor perfo	rmed?	death?	completion of cause of
ita	sicien: The law certificate has l irector, page 2 s	Bec	25. Was case referred to medical examiner?	UNC					26. Place	of Death	(Check only o	•		
<u>&gt;</u>	Physic this ce al dire	ဥ	1 ☐ Yes 2 ☑ No	-		ER/Outpatier	nt 3 🗆 D	Othe Othe	er: 4□Nu	rsing Ho	ne 5 Resid	dence	6 □Other (Sp	ecify)
c C	ing P	ë ë	27. Manner of Death 1	28a. Date of (Month,	Injury Day Year)	28b. Time o Injury		28c. Injury Work			28d. Describe I	now injur	y occurred	
Sio	tendi leath tor: / the fu	catl	2 Accident investigation 3 Suicide 6 Could not t				М		Yes 2		204 1	2	(4)	
Division of Vital	f or Attending I after death. Director: After I in by the funer	Certification:	4 ☐ Homicide determined	286. Place of	i injury - At n i, etc. <i>(Speci</i>	ome, farm, str fy)	reet, factor	y, office			City or Tox			Rural Route Number,
	Hospitel 4 hours Funeral ely filled	edical C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the b	is of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) date and	and manner a	as stated. ee to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of ceptifier	and manne	r stated.		29	c. License	number			29d Dat	e signed (Mor	oth Dev Year)
	F≯F8		6/11/	eentaus	7	aax		7/	10011	10		/	10/1	1000
	1		30. Name and address of person who	completed cause	of death (Iter	m 23a) (Type.	Print)	09	534	7		04	100/2	-606
	$\mathcal{O}$		SURESH DHANJAN	10 2 2	225.	UNION	SUE	· W	AVRE	DF C	RACE	40:	21078	
	Sta		21 Data filed (Month Day Vane)	006 32 Reg	istrar's Sign	No do	242	1	.,,,,,	7	,/			
	Registr	ar	UI II T T	COO CONTRACTOR	Street of									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 04 **Physician** 21,33 05 Louise /Medical Spriggs 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARITAY HOSPITAL Baltimore NA If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month Day Year) **Funeral**  Birthplace (State or Foreign Country) Months Days Hours Min 212-44-8201 S.C. Director 84 Usual Residence of Decedenl death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Items 23a or 28a-f show The Medical Examinar must be notified at Director 1X Yes 2 No Md. NA Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 1524 Mountmor Court 21217 USA Funeral 12. Was Deceden| Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Black Completed by Specify: 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Homemaker Seamstress Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ant of Health and Mental Hit: If Item 27 Is marked oth y or other traumatic even Be Cleveland ၉ Grover Drummond Mammie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1629 Kingsway Rd., Baltimore, Md. Yulanda H. Vaughan Grandfather 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Department i Important: If any injury or once. King Memorial Park 4-13-06 Randallstown, Md. 21. Signature of Funeral Service Licens 22. Name and Address of Facility Baltimore, Md. 21202 March F.H. East 1101 E. North Ave. 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dealh) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 ☐ Unknown 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has blirector, page 2 s cougest rmed? 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🗙 No 1 Inpalient 2 ER/Outpatient 3□ DOA within 24 hours after death.

To the Funerel Director: After th completely filled in by the funeral 27. Manner of Death 28c. Injury al Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State)

P.O. I of Vital Records, To the Hospital

31. Date filed (Month, Day, Year) State APR 1 1 2006 Registrar

29b. Signature and title of certifier

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type. Print)

1) with Souzdalnitski 5601 Locu Ravey Blvd, Baltimore, MD

21235



Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Res 000

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Stete Registrar Amend Item #5 per FH g854 4/ \*Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 9:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford ther deer ower Under 1 Year If Under 24 Hrs. onths Days Hours Min. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) ec42 N4069 6. Sex 8. Date of Birth (Month, Day) **Funeral** Months 12 M 2□F 72 Director 1696 6 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f show other treumetic event, the Mudical Examiner must be natified at 1 Yes 2 No HARFORD Be Completed by Funeral Director DERMEEL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a OWER 21001 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify Yas Give Specify: 3 ₩Widowed 4 Divorced White Year or Dates: "naturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or To-Importent: If item 27 lean any injury or other treun 2008. Tower 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Deremation 3 Removal from State \* 4 □ Donation = 5 □ Other (Specify) 21. Signature of Funeral Service I OREST HILL, MD 23a. Part . Enter the disease, or complications that cause shock, or heart failule. List only byte cause on each in Approximate Interval Between Onset and Death the death. Do ut enter the mode of dying, such as cardiac or resultratory arrest Immediate Cause (Final ( Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 Other (specify) should be detached 9☐ Unknown 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Unknown 3 Probably 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate 1 🗌 Yes 2 No 1 TYes To the Hospital or Attending Physicien: director, 25. Was case referred to medical 26. Place of Death (Check only one examiner? Hospital: Other: 1 Yes 1 🗌 Inpatient 2 ER/Outpatient 4 ☐ Nursing Home Seridence 6 ☐ Other (Specify) 3□ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No within 24 hours after death. To the Funerel Director: A investigation completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) and who completed cause of death (Item 23a) (Type, 30. Name and address of person 31. Date filed (Month, Day, Year) 2. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 1 5 1 - For State Ragistrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 41:25 am **Physician** OH Barbara E. Sewell 06 O8 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner hosedale Ba Franklin Square Itimore Hospital Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | Sept. 21,1917 | 7 | Maryland 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 □ X 88 215-01-6571 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location ir then "naturel", or Items 23a or 28a-1 show the Medical Examinar must be notified at Middle River 1 Yes 2 No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 2116 Firethorn Road 21220 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 XNo 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify Specify: White If Yes, Give Year or Dates: ģ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "na eny Injury or other traumatic event, I'm Maulic 2008. Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 9th 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be ( Lillian Mary Rose Frederick Buettner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2166 Firethorn Road Baltimore MD Barbara E. Leonard Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)
Gardens of Faith 20c. Location - City or Town, Slate Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/11/06 Rossville MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signalure of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death on not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List entry one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician **Physici** Sepsis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): attending physicien of for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4 Pregnant at time of death 9 Unknown 9 Unknown s been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certification; To Be Completed by 1 Yes 2 100 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificete 1 Yes 2 1 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 1 Inpalient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospitel or Attending Phys within 24 hours after death.

To the Funerel Director: After this completely filled in by the funeral di 28a. Oate of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 1 Matural 5 Pending 1 Tyes 2 No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of gertifier 586 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Square 9000 Drive Isherina Amdo 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** INEZ D. SANTILLI 10:47 PM APRIL 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ROSSVILLE BALTIMORE GENESIS FRANKLINWOODS Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11/3/1907 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🖾 F PENNSYLVANIA Director 98 212-44-1344 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County item 27 is marked other than "natural", or items 23e or 28e-f show other treumstic event, the McCical Examiner must be notified at 1 ☐ Yes 2 ▼No Director PERRY HALL BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA AMBERLEIGH LANE 21128 9601 F. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: δ 3 X Widowed 4 □ Divorced WHTTE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SELF EMPLOYED is 2 should be filed with and Mental Hygier 7 is marked other the SEAMSTRESS 8TH GRADE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ASSUNTA VARATTO ANGELO SANTASTEFANO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s of Health an 9601 F. AMBERLEIGH LANE PERRY HALL, MD 21128 JEANNETTE HUDAK/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Depertment of H Important: if ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4/10/2006 BALTIMORE, MD MOST HOLY REDEEMER 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY
22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee 8521 LOCH RAVEN BLVD. TOWSON, MD 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END -STAGE DEMENTIA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner law requires that the death certificate be executed sete has been signed by the attending physicien and page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 HTH 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed DIABETES 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2× No 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; : After Natural 5 Pending Injury death. М 1 ☐ Yes 2 ☐ No 2 Accident investigation efter death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide

Division of Vital Records, P.O. Box 68760 completely filled in by To the Hospital o within 24 hours eff To the Funeral Di

> State Registrar

Medical

(Check only

29b. Signature and title of certifier

ARSHALL 105 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANKLIN SQUARE DR. BALTIMORE 33. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

D4000

8

29d. Date signed (Month, Day, Year)

		1 - State Registrar	State of N	faryland / [	Departmer Certifica				Reg. No.	006	Permanental	71
<b>Physici</b>	an	Decedent's Name (First, Middle, Las.)			<b>a</b> .			2. Date of Dea Month	Day	Year	3. Time of	
/Medic	_		Iola	Lucinda				April	8,	2006	9:30	A
Examin	ner	4a. Facility Name (If not institution, give			4b. City	, Town, or Local				ounty of Death		
0 K	w) .	Corsica Hills E		Age (In yrs. last bir	thday) If Unde	Centres or 1 Year   If Ur	nder 24 Hrs.	8. Date of Birt		ueen Ar		or For
Funeral Director			□M 2 <b>X</b> F		Yrs. Months			8. Date of Birt (Month, Dat <b>June</b> 30	, 19	11 Ne	pplace (State of intry) W York	
MOI		10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside Ci	ity Lir
Part of	tor	MD Queen A	nnes			Centre	7i11e				1 Tyes	2 <b>X</b>
gene. r then "naturel", or frema 23a or 28a-f ehow Ina Medical Examinar must be notified at	Director	10e. Street and Number			10f. Zi	p Code			10g. Citize	n of What Cou	untry?	
23a	ral	205 Armstrong Av					l617			USA		
tema Term	Funeral	11. Marital Status	12. Was Deceden Armed Forces	5?	13. Was Dece If Yes, spi	edent of Hispanie ecify Cuban, Me:	: Origin? (Sp kican, Puerto	ecify Yes or No- Rican, etc.)	. 14	<ul> <li>Race - Amer</li> <li>Black, White</li> </ul>		
or a	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Tyes 2 1 If Yes, Give Year or Dates		1 ☐ Yes	2 No Spe	icity:		S	pecify: Lib	ite	
en E	edt	15. Decedent's Edi			. Decedent's Usi	ual Occupation			16b, Kind	of Business/li		
n "n	Completed	(Specify only highest grad			(Give kind of will life. DO NOT to	ork done durina	most of work	ring			,	
1	Eo	Elementary/Secondary (0-12)	College (1-40)		Legal Se	ecretary	7		State	e Gover	nment	
od other	Be C	17. Father's Name (First, Middle, Last)				18. N	lother's Name	e (First, Middle,	Maiden Su	ımame)		
marked o	2	unk.		Donald.	son		Iola	Lucino	la Su	utherla	and	
itam 27 is marke othar traumatic		19a. Informant's Name/Relationship (T		19b	. Mailing Addres	s (Street and No	ımbər or Run	al Route Numbe	or, City or T	own, State, Zi	ip Code)	
n 27		James E. Steeves,	son		.0. Box			ay, Mary		21607		
of fram of other		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ I	Removal from Stat	e cemeter	f Disposition (Na ry, crematory or	other place)		Date	20c. Loca	tion - City or T	own, State	
ant		4 □Donation 5 □ Other (Specify,	)	Metro	Cremato			.0/06	Ba1	timore	, MD	
Important: If its any injury or o		21. Signature of Funeral Service Licens	George	MacNabb	22. Name a	and Address of F	O.	remation k Road				
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause	ed the death. Do r	not enter the mo						Approximate Interval Bets	е
/sician		Immediate Cause (Final disease or condition	Pneum								Onset and I	
ledical		resulting in death)	d	is a consequence	of):						T MEEV	-
aminer		Sequentially list conditions.	b									
÷ is	luei	Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequence	of):							
hysician and the burial-transit	Examine	that initiated events resulting in death) Last	C. Due to (or a	a consequence	of).							
cian			D00 10 (01 a	3 & CONSOQUENCE	Jij.							
(7 m	100		d.									
phys the	-			e of pregnancy					224	d. Date of deliv	(AD)	
iding phy ise as the	/Me	IF FEMALE:	23c. If ves. outcom	- VI PIDUIDIILV							и өт у	
attending p for use as	clan/Me	23b. Was decedent pregnant in the past 12 months?		2 Fetal death					230	Month	Day 1	Year
attending p for use as	ysiclan/Mec	23b. Was decedent pregnant	1 ☐ Live birth	2 Fetal death at time of death	3 ∏Ectopic p 5 ☐ Other (s				230		Day 1	Year
attending p for use as	y Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No	1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2  Fetal death at time of death	5 🗌 Other (s	pecify)	art I.	23e. Did to				
gned by the attending p be detached for use as	þ	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live birth 4 Pregnant 9 Unknown	2  Fetal death at time of death	5 🗌 Other (s	pecify)	art I.			Month contribute to		leath
been signed by the attending p should be detached for use as	þ	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  Part II. Other significant conditions co	1 Live birth 4 Pregnant 9 Unknown	2  Fetal death at time of death	5 🗌 Other (s	pecify)	art I.	1 ☐ Y	obacco use 'es 2	Month  contribute to	the cause of d	Jnkn avai
has been signed by the attending p je 2 should be detached for use as	þ	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  Part II. Other significant conditions co	1 Live birth 4 Pregnant 9 Unknown	2  Fetal death at time of death	5 🗌 Other (s	pecify)	'art I.	1 🗆 Y 24a. Was autop perfor	obacco use es 2 de an an an an an an an an an an an an an	Month  contribute to  0 3 Pro  24b. Were aut prior to codeath?	the cause of dibably 4 []Copsy findings completion of ca	Jnkn avai
ate has been signed by the attending p page 2 should be detached for use as	e Completed by	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ™ No 9 □ Unknown  Part II. Other significant conditions co  Alzheimer's, De	1 Live birth 4 Pregnant 9 Unknown	2  Fetal death at time of death	5 🗌 Other (s	cause given in F		1  Yas autop perfor	obacco use 'es 2 an sy 'med? 2 No	Month  contribute to  No 3 Pro  24b. Were aut	the cause of dibably 4 []Copsy findings completion of ca	Jnkn avai
certificate has been signed by the attending prector, page 2 should be detached for use as	Be Completed by	23b. Was decedent pregnant in the past 12 months? 1 Tyes 2 Mo 9 Unknown  Part II. Other significant conditions co  Alzheimer's, De	1 Clive birth 4 Pregnant 9 Unknown ontributing to death	2 Fetal death at time of death but not resulting in	5 ☐ Other (s	cause given in F	Place of Deatl	24a. Was autop perfor 1 Yes	obacco use yes 2 an sy rmed? 2 an ne	Month  contribute to  No 3 □ Pro  24b. Were aut prior to co death? 1 □ Yes	the cause of dibably 4 \( \subseteq \text{U}\) opsy findings a completion of calculations.	Jnkn avai
this certificate has been signed by the attending p al director, page 2 should be detached for use as	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No  9 □ Unknown  Part II. Other significant conditions co  Alzheimer's, De  25. Was case referred to medical examiner?  1 □ Yes 2 □ No  27. Manner of Death	1 Live birth 4 Pregnant 9 Unknown entributing to death enentia	2 Fetal death at time of death but not resulting in	5 ☐ Other (s	cause given in F	Place of Deatl	1  Yas autop perfor	obacco use Yes 2 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Month  contribute to  No 3 □ Pro  24b. Were aut prior to a death? 1 □ Yes  □Other (Special Contribute of the contribute	the cause of dibably 4 \( \subseteq \text{U}\) opsy findings a completion of calculations.	Jnkr ava
this certificate has been signed by the attending p al director, page 2 should be detached for use as	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 MNo 9 □ Unknown  Part II. Other significant conditions co  Alzheimer's, December 25. Was case referred to medical examiner?  1 □ Yes 2 No	1 Clive birth 4 Pregnant 9 Unknown ontributing to death	2 Fetal death at time of death but not resulting in	5 ☐ Other (s	cause given in F	Place of Deatl	1 TY  24a. Was autop perfoi 1 Yes  h Check only or	obacco use Yes 2 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Month  contribute to  No 3 □ Pro  24b. Were aut prior to a death? 1 □ Yes  □Other (Special Contribute of the contribute	the cause of dibably 4 \( \subseteq \text{U}\) opsy findings a completion of calculations.	Jnkn avai
this certificate has been signed by the attending p al director, page 2 should be detached for use as	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	1  Live birth 4  Pregnant 9  Unknown ontributing to death ementia  Hospital: 1  Inpat 28a. Date of li (Month, D	2 Fetal death at time of death but not resulting in	5 Other (s	cause given in F  26. F  OA Cther: 4 6  28c. Injury at Work? 1 □ Yes	Place of Deatl	1 TY  24a. Was autop perfoi 1 Yes  h Check only or	obacco use  Yes 2 1 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	Month  contribute to  No 3 Pro  24b. Were aut prior to cideath? 1 Yes  Other (Special Control of the control of	the cause of dibably 4 L Copsy findings completion of cities 2 No	Jnkn avai ause
this certificate has been signed by the attending p al director, page 2 should be detached for use as	Certification: To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	Hospital:  28a. Date of In (Month, D)  28e. Place of Is building, of the basis	2 Fetal death at time of death but not resulting in tient 2 ER/Ou jury any Year) 28b. 1 In figury - At home, fa etc. (Specify)	5 Other (s  n the underlying  utpatient 3 D  Time of njury M  urm, street, factor	cause given in F  26. F  OA Cther: 4 2  28c. Injury at Work? 1 Yes  ry, office	Place of Death Nursing Ho 2  No	24a. Was autop performed to the common service of the common servi	obacco use  /es 2 4  an 2  sy ymed? 2 2 No  ne)  lence 6 [ lence 6 [ lence 7, State)  cause(s) ar	Month  contribute to  No 3 Pro  24b. Were aut prior to or death? 1 Yes  Other (Special Cocurred)	the cause of dibably 4 \( \text{L} \) opsy findings ompletion of cause Num  fy)	Jnkn avai ause
ey nous arion beau. Funeal Director: After this certificate has been signed by the attending pately filled in by the funeral director, page 2 should be detached for use as	To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	Hospital:  28a. Date of In (Month, D)  28b. Place of Is building, 4	2 Fetal death at time of death but not resulting in tient 2 ER/Ou jury any Year) 28b. 1 In figury - At home, fa etc. (Specify)	5 Other (s	cause given in F  26. F  OA Other: 4 1  28c. Injury at Work? 1  Yes  ry, office  d at the time, dat n, in my opinion,	Nursing Ho 2 No e and place, death occurr	24a. Was autop performed at the time.	obacco use  yes 2  an sy rmed 2 2  No ne) dence 6 [ freet and h n, State)  cause(s) ardate and pl	Month  contribute to  No 3 Pro  24b. Were aut prior to ce death? 1 Yes  Other (Special cocurred	the cause of dibably 4 L Copsy findings ompletion of cause (Stated, to the cause (stated)	Jnkn avail ause
ther this certificate has been signed by the attending p funeral director, page 2 should be detached for use as	edical Certification; To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	Hospital:  28a. Date of In (Month, D)  28e. Place of Is building, of the basis	2 Fetal death at time of death but not resulting in tient 2 ER/Ou jury any Year) 28b. 1 In figury - At home, fa etc. (Specify)	5 Other (s	26. FOA Cther: 4 28c. Injury at Work? 1 Yes ry, office	Nursing Ho 2 No e and place, death occurr	24a. Was autop performed at the time.	obacco use  yes 2 1  an sy yemed? 2 2 1  No  lence 6 [ covering to the sy treet and h  m, State)  cause(s) ar date and pl  29d. Date s	Month  contribute to  No 3 Pro  24b. Were aut prior to codeath? 1 Yes  Other (Special Cocurred)  Number or Ruind manner as ace, and due issigned (Month)	the cause of dibably 4 \( \buildrel{\text{L}} \) opsy findings completion of city 2 \( \buildrel{\text{NO}} \) No  and Route Num  stated. to the cause(s	Jnkn avail ause
ey nous arion beau. Funeal Director: After this certificate has been signed by the attending pately filled in by the funeral director, page 2 should be detached for use as	edical Certification; To Be Completed by	23b. Was decedent pregnant in the past 12 months?  1	Hospital: 1 Inpat  28a. Place of It building, 4  28b. Place of It building, 4  resician: To the bessiner: On the basis and manner s	2 Fetal death at time of death but not resulting in tient 2 ER/Ou jury 28b. 1 In pury - At home, fall setc. (Specify)	other (s	cause given in F  26. F  OA Other: 4 1  28c. Injury at Work? 1  Yes  ry, office  d at the time, dat n, in my opinion,	Nursing Ho 2 No e and place, death occurr	24a. Was autop performed at the time.	obacco use  yes 2 1  an sy yemed? 2 2 1  No  lence 6 [ covering to the sy treet and h  m, State)  cause(s) ar date and pl  29d. Date s	Month  contribute to  No 3 Pro  24b. Were aut prior to ce death? 1 Yes  Other (Special cocurred	the cause of dibably 4 \( \buildrel{\text{L}} \) opsy findings completion of city 2 \( \buildrel{\text{NO}} \) No  and Route Num  stated. to the cause(s	Jnkn avail ause

			1 - For State Registrar	State of Ma	ryland /		artment of F tificate of		Mental Hy	giene Reg. No	CHUB	11175
	Physici	an	Decedent's Name (First, Middle, La	,					2. Date of De Month	aath Da	y Year	3. Time of Death
	/Media		Mary Josephine Sm	ith					Apr	7,	2006	6:50 P <sup>M</sup>
À	Examir	ner	4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, a	r Location of Deat	th	4c	. County of Death	
			15265 Barnes Rd.				New Wind				Carroll_	
Ċ	Funeral Director			ex	(In yrs. last b	irthday) Yrs.	Months Days	If Under 24 Hrs Hours Min.		th ay, Year) 19	9. Birthp Coul Lowa	place (State or Foreign ntry)
	and w		Usuel Residence of Decedent  10a. State 10b. County		10c. City, Tov	wn or Lo	cation					10d. Inside City Limits
	Aaryl f • ho	ō	Monvel and Course 11									1 ☐ Yes 2 ☑ No
	the 28a-	ect	Maryland Carroll  10e. Street and Number		New Wi	nas	10f. Zip Code		· · · · · · · · · · · · · · · · · · ·	10a Cit	izen of What Cour	ntn/?
	with se or	<u></u>										•
	leath	era	15265 Barnes Rd.	12. Was Decedent E	ver in IJS	13 \	21776 Vas Decedent of H	ispanic Origin? (S	Specify Yes or No		ted Stat 14. Race - Americ	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23e or 28e-f ehow enty injury or other traumatic event, I'm Medical Examinar must be notified at anote.	by Funeral Director	1 ☐ Never Married 2 ☐ Married  3XXWidowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ N If Yes, Give		1	Yes, specify Cuba	n, Mexican, Puer Specify:	to Rican, etc.)		Black, White,	
5-0036	hour ture	Pa Da	15. Decedent's Ed	Year or Dates:	160	Dacad	lent's Usual Occup	ation		16h K	ind of Business/In	
<u>.</u>	n 72	Completed	(Specify only highest gra	de completed)		(Give	kind of work done OO NOT use retired	during most of wo	rking	16D. K	ing of Business/in	dustry
2121	with than	Ē	Elementary/Secondary (0-12)	College (1-4or 5-	,		aker	,		ho	r home	
0	filed Hyg Sther		17. Father's Name (First, Middle, Last)		110	unem	ikei	18. Mother's Nar	me (First, Middle			
aryland	id be ked of c ev	To Be	Joseph Vaura					Barbara	Tomashe	k		
2	shound M	-	19a. Informant's Name/Relationship (	Type, Print)	19	b. Mailin	g Address (Street				or Town, State, Zic	Code)
Σ	od 2 Ith a 27 is		Carol Scott (daug	hter)			oster Kno				1085	
ē,	F Hearlism other		20a. Method of Disposition				sition (Name of natory or other place		Date		ocation - City or To	own, State
altimore,	age ento nt: if		XX Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific				oln Cem	4/12/2	2006	Fren	twood, M	ח
₫	artme ortar injur		21. Signature of Funeral Service Licer		LOLU I	-	. Name and Addre		.000	DI CII	twood, II	<i>D</i>
B	Depa Impo eny ir	r i	Volde 1	111					al Home	and	Cremato	ry, P.A
			23a. Part1. Enter the disease, or com	olications that caused	he death. Do	not ent	or the mode of dying	Liberty g, such as cardia	C or respiratory a	ntic rrest,	1d, MD 2	Approximate
	Dhysician		Immediate Cause (Final	one cause on each line	).	4	0 -					Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a	Cen	2	the ga	nenis	4		1	nonthy
	Examiner			Due to (or as a	consequence	Olj.						
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	or):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events									
o,	exectin an rial-tr		resulting in death) Last	Due to (or as a	consequence	of):						
98760	ificate be executed g physician and as the burial-transit	edical	· ·	d								
_	tifica ng ph as th					-						
Box	h cer endir r use	N/CE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 7	Ectopic pregnancy				23d. Date of delive	ery
	deat	Sicle	in the past 12 months? 1 Yes 2 100	4☐Pregnant at t			Other (specify)				Month	Day Year
O.	law requires that the death certif as been signed by the attending 2 should be detached for use a	Physician/M	9 ☐ Unknown	9□ Unknown								
	as the	by F	Part II. Dther significant conditions c	ontributing to death but	not resulting	in the ur	derlying cause giv	en in Part I.	23e. Did	obacco i	use contribute to the	he cause of death?
Vital Records,	w require been sig should b								1 🗆	Yes 2	<del>□No</del> 3 □ Prob	ably 4 Unknown
ပ္က	awre is be	Completed							24a. Was		24b. Were auto	psy findings available
ř	The lay	E							auto perfo	psy rmed? 2. <del>2.No</del>	death?	mpletion of cause of 2 No
<u>a</u>		BeC	25. Was case referred to medical				<del></del> -	26. Place of Dea	ath (Check only		1 192	2010
	ysici is cer direc	ToB	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 ER/O	utpatien	3□ DOA Oth				6 ☐ Other (Specif	(v)
0	g Phy erthii		27. Manner of Death	28a. Date of Injury (Month, Day	28b.	Time of	28c. Injun Worl		28d. Describe			,,
Division of	uttending F death. ctor: After y the funer	ate	1.☑Natural 5 ☐ Pending 2 ☐ Accident investigation		(Gai)	Injury		Yes 2 □ No				
SIN	Atts	=	3 ☐ Suicide 6 ☐ Could not be determined	286. Place of injul	y - At home, f	arm, stre	et, factory, office		28f. Location (	Street an	d Number or Rura	I Route Number,
5	s afte	Certification:	Tomolog	building, etc.	(Specify)				City or To	WII, State	7	
	To the Hospital or Attending Physicien: whithin 24 hours stee deals the Condition To the Funeral Director: After this certific completely filled in by the funeral director,	edical (	29a. Certifier (Check only one)	ysician: To the best of iner: On the basis of e and manner state	examination as	e, death	occurred at the tin estigation, in my o	ne, date and place pinion, death occu	e, and due to the irred at the time,	cause(s) date and	and manner as si d place, and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and fittle of certifier				29c. Licenso	number		29d. Da	te signed (Month,	Day, Year)
)			) Chr	n H .	6 1 -	v~ (	DI	7105		41	10/06-	
Ì	Y		30. Name and address of person who	completed cause of de	ath (Ite 3a)	(Type, I		1, 0 3		//	, -,	
6	7		Civits Milton	Hensata.	Alt	NI	Windsor.	NID				
	Sta	te	31. Date filed (Month, Day, Year)	20 Decistra	's Signature	y -	VIII (1.20)					
	Registr		APR 1 1 200	16 Heren	M	Sing.	Par.					
DHN	AH 17 Rev 1/20	001	1 1 200	· Junger	-							

DHMH 17 Rev 1/2001

ORIGINAL

DHMH 17 Rev 1/2001

SON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month RIL 2006 Ø3:58 FM **Physician** Gordon Robert Thompson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Center Saint Joseph Medical Months Days Hours Min. 8. Date of Birth May 05, 1924 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** New Jersey 1XXM 2□ F 143-16-9510 81 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Health and Mental Hygiene. Int: If item 27 ie marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location the Medical Examiner must be notified at 1 ☐ Yes 2 No Parkville Director Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 7809 Oakdale Avenue Completed by Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc 1xx Yes 2 No WWII If Yes, Give Year or Dates: Korea 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Salesman Mobil Oil Corporation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Martin F. Thompson ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Betty W. Thompson - Wife 7809 Oakdale Avenue Parkville, Maryland 21234 item 27 i 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Depertment of H Important: If ite eny Injury or ot pnce. 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkwood Cemetery 04/13/2006 Parkville, Maryland Augeral Seminal Sensee Charles Miner 5305 Harford Road 22. Name and Address of Facility 21. Signature Leonard J. Ruck, Inc. Baltimore, MD 21214 implications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or co shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) CARDIO-RESPIRATORY ARREST Physician /Medical Due to (or as a consequence of): Examiner PULMONARY EMBOLISM Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of): Examine ettending physicien end for use as the burial-transit RIGHT VENTRICULAR THROMBOSIS Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown VENTRICULAR ARRYTHMIA Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an LACTIC ACIDOSIS 1 Yes 2 No 1 ☐ Yes 2 No RENAL INSUFFICIENCY I or Attending Physician: after death. Director: After this certifice .25. Was case referred to medical 26. Place of Death | Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 1 Natural
2 Accident 5 Pending 1 Yes 2 No investigation filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the th

(04)

State Registrar

LINTHICUM, M.D. RICHARD 32. Registrar's Signature 31. Date filed (Month Play, Year)

29b. Signature and title of certified

withicula

29d. Date signed (Month, Day, Year)

D31826

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OSLER DRIVE 7601

29c. License number

TOWSON, MARYLAND 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 47P M AMonth Year **Physician** 2006 HNNA Hompson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore Franklin Square

5. Social Security Number 6. Sex Kosedale
If Under 1 Year | If Under 24 Hrs. Hospital center 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min. 1 M 2 F 216-01-8211 Director 10/30/1919 MARYIAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iteme 23a or 28a-f show other traumatic event, the Medical Examiner must be notified a 1 ☐ Yes 2 ☐ No Director BALTIMERE MD BALTIMERE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 220 21236 4102 APT. USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ NO Specify: Specify: 3 ₽ Widowed 4 □ Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) le marked other then Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY NATIONAL permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any njury or other traumatic event 900.6. 17. Father's Name (First, Middle, Last) (8. Mother's Name (First, Middle, Maiden Sumame) Be MATILDA EVERSMEYER MIEYERS ဥ GEORGE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 ISALTIMORE, MO - DAUGHTER HUE 21236 JOYCE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20p Location - City or Town, State APRIL cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State CEMETERY TARKWOOD MRKUILLE MD 4 ☐ Donation 5 ☐ Other (Specify) 10, 2006 21. Signature of Faneral Service Licensee HARFORD RD MARKVITE CHAPEL MD 21234 Per 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) . Severe Depsis **Physician** /Medical Due to (or as a consequence of Examiner secondary to small bewel obstruction chemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Severe Due to (or as a consequence Box 68760, Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No coliti Ischemic s after deau...
rel Director; After this communic by the funeral director, pr 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☑ No Medical Certification: To 1 hoatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manyler of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funeral C completely filled Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) MD

Registrar DHMH 17 Rev 1/2001

State

omPson

9000 Franklin

30. Name and address of erson of completed cause of death (Item 23a) (Type, Print)

2006

D58631

Square Drive, Baltimore, MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** McDonald Grant Thomas 2006 7:25 A April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Center tf Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 1 M 2 F **Funeral** Yrs MD March 6 1932 74 Director 212-30-2764 Usual Residence of Decedent 10d Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County ir than "natural", or Itams 23a or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Monkton Director MD **Baltimore** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21111 16737 Hereford Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 Yes 2 No black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Balto. County Roads Cement Finisher 7 n/a 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If item 27 is marked othe sny injury or other traumatic svent, odge. 17. Father's Name (First, Middle, Last) Be Mary Eleanor Cromwell MacDonald Grant Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16737 Hereford Rd., Monkton, MD 21111 Marnette D. Thomas/wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 4/11/06 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD 21093 21. Signature of Fineral Service Licensee Bryan W. Clary 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Ca. se (Final disease or con tition resulting in death Stroke Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: Box 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day ō in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ے 23e. Did tobacco use contribute to the cause of death? s been signed beta Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
1 Yes 2 No page 2 s 1 ☐ Yes 2 ☐ No certificate Vital director 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify NO19) 4 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ 1 ☐ Yes 2 No ō After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification; 11 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completaly filled in by the fu investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 | Homicide 0 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier APML7, 2006 058303 arlus

State

Registrar

31. Date filed (Month, Day, Year)

2006



Sr Baltmare

ms 2120

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARY RNER 6:55 2006 OL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ANN ARUNDEL BURNIE MARINER HEALTH GEN If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 11-14-1434 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) **Funeral** Days 212-32-9418 1 ☐ M 2 😿 F Yrs. Director Usuel Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or Itams 23a or 28a-f show the Medical Examinar must be notified at 1 ☐Yes 2 KNo Funeral Director GLEN BURNIE MD ANN ARUNDEL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21061 6674 USA ROBERT COURT death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: BLACK δ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) nd Mental Hygiene. marked other than College (1-4or 5+) DOMESTIC HOME MAKER 9 TH GRADE NA permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 is marked other eny injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ROBERT THOMPSON BEE BENNET 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILBERT TURNER (HUSBAND) 6614 ROBERT COURT GLEN BURNIE Baltimore, 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GLEN HAVEN 04-10-06 GLEN BURNIE! \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lices 22. Name and Address of Facility
VAUGHN C- GREENE FUNERAL SERVICE
5151 BAYO. NAT. PIRE, BALTO. MD 21229 aughn 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Metastatto breas Physician months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Be Completed by ed bluods 1 ☐ Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 22No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical npletely (Check only one) within 2. To the F and manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signat up and title of certile uding Physician 029873 04/06/06 defending 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RITA CHANDELWAL ALD (ECO S. CRATN HUY, FF Cro, Clen Browne 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#19a, perInf, PH, 0854, 4/19/00 TI State of Maryland / Department of Health and Mental Hygiene, O. C. 1 - For State Registra Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5\_ April 6:40 P M Adrian C. Torres 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 224 Grand Drive Taneytown Carroll Co. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. XXM 2 F Yrs. Director 125-18-0385 90 16, 1915 Puetro Rico Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d, Inside City Limits or 28a-f show other traumatic event. The Medical Examiner must be notified at Maryland Carrol1 1 Yes 2 No Taneytown Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 224 Grand Drive 21787 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ⊋Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 15 Yes 2 E-No Specify: Specify: Hispanic þ 3 Widowed 4 Divorced Year or Dates: WWII natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Commerce 7 Years Merchant Marine 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ Epifanio Torres Marcelina Candelaria 19a. Informant's Name/Relationship (Type Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health Mrs. Janice Wenck 224 Grand Drive Taneytown, Maryland 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. 1 🔀 Burial 2 □ Cremation 3 □ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 4/11/2006 Middle River, MD 21. Signature of Funeral Sanice License Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. 7922 Wise Ave. Approximate Interval Between Onset and Death ot enter the mode of dying, such as cardiac or respiratory arrest, onges Immediate Cause (Final Physician tive Comonitu disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) o detached ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð OBSTRUCTIVE DUMONACY 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 2 **X**No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 1 Tes 2 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 this 27. Manner of Leath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification; After Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2 To the the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 731660 06/2006 cousty mos trancis 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 1/2001

1 2006

THOMAS GALVIN MA

31. Date filed (Month, Day, Year)



2911

WES OMIN STER MALLAND 21157

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State Registrar Alok Mathur, M.D.
31. Date filed (Month, Day, Year)

2006

32 Registrar's Signature

4000 Olney-Laytonsville Road, Olney, Maryland 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#2, perint C85/4, 4/19/2006 TT State of Maryland / Department of Health and Mental Hygiene State Registra**A**mend Item **200** Per Phy G854 4 **Agniticate** of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 95, Day Physician Year PAULINE ROSE WILCOX 2006 6:35 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 10634 Hesperian Drive Laurel Howard If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 128-24-8051 Yrs Director 73 1, Dec. 1932 New York Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location r then "naturel", or items 23s or 28s-f ehow the Medical Examinational be notified at 10d, Inside City Limits 1 ☐ Yes 2 ☐ No XX Director MD Howard Laurel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10634 Hesperian Drive 20723 Funeral U.S.A. 12. Was Decedent Ever in U.S. Amed Forces?
1 Yes 2 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: þ Specify: 3 XWidowed 4 □ Divorced White Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grade 12 Bookkeeper Jewelry Store other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked othing any lighty or other treumatic event, SDR. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas A. Thomsen Claire Hanfit 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Fitzgerald / daughter 10634 Hesperian Drive Laurel, Maryland 20723 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State MD Veterans Cemetery 4/12/2006 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility al Home, P.A. auce and he M00160 313 Talbott Avenue Laurel, Maryland 20707 26a. Parf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic non-small cell lung cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner nding physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ळo 23d. Date of delivery for u 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) detached been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed?
1 ☐ Yes 2 ∑ Xio 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 🛛 Xo 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home STAResidence 6 Other (Specify) ٩ 1 ☐ Yes 2 💢 💢 o 2 ☐ ER/Outpatient 3 ☐ DOA this neral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 XX Matural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 06

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

3 Registrar's Signature

Martin Weltz, M.D.

31. Date filed (Month, Day, Year)
APR 1 1

D 23743

7525 Greenway Center Drive Greenbelt, Maryland 20770

April 4,

2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mary Evelyn Wagner April 8, 2006 2:20AM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth Month, Day, Year) JULY 13,1910 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2**□**F Mary land 212-09-7300 95 Director Usuel Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10d. Inside City Limits r then "nstural", or iteme 23a or 28a-f show the Medical Expreiser must be notified at 1 ☐ Yes 2 😿 No Funeral Director MD Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15 Treeway Court Apt. 1C 21286 U.S.A. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specity: ģ Specify: White 3 ¥ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Accounting Firm nd 2 should be filed with and Mental Hygier 27 is marked other the treumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hardecker John Adam Kirkham Ella 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Depertment of Health and Important: If Item 27 Is m eny injury or other treum once. Mary Wagner- Daughter 15 Treeway Court Apt. 1C Towson, Maryland 21286 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 4/12/06 Baltimore, Maryland 21. Signature of Funeral Service Licensee Heather Cain 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Congestive Heart failure YEGES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed? certificete 1 Yes 2 dNo within 24 hours after death.

To the Funaral Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Sother (Specify) 1 ☐ Yes 2 Ne 2 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Anatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Medicai 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20061199 April, 8, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Black 6601 NorThCharles St, lowson MO 21204 Jason

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registr Amend Item #8 & 20b Per FH G856 et Hill Care of Beath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 12:14 PM WOOD **Physician** FIPRIL 2006 EDWARD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BACTIMORE Norte HOSPITAL RANDACCSTUWN ~IDEST If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Var) 26 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex 5. Social Security Number **Funeral** tookM 2□F 79 Pennsylvania 199-12-4408 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County th and Mental Hygiane.
7 is marked other then "naturel", or iteme 23a or 28e-f show treumatic event, the Moulcal Examinar must be notified at 1 ☐ Yes 2X No Director Baltimore Halethorpe 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21229 1201 Maiden Choice Lane deeth Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 72 hours after tyttes 2 □ No If Yes, Give Year or Dates: 1 Never Mamed 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced 1945-46 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland Accountant 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be 2 John Wood Agnes Healy 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2:
Depertment of Health at Important; If Item 27 le eny injury or other treugnes. 1216 Maiden Choice Lane; Halethorpe, MD 21229 Patricia Wood Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1171 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Park 4/11/2006 Elkridge, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke Funeral Home of CatonsvIlle, Inc. 21. Signature of Funeral Service Licens 1630 Edmondson Avenue; Catonsville, Ma 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death HEART FAILURE Immediate Cause (Final CONGESTIVE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (ur as a consequence of) in any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed buriel-transit and resulting in death) Last Due to (or as a consequence of) Box 68760, attanding physicien for use as the burie Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached P.O. 9 Unknown 9 ☐ Unknown certificete hes been signed by rector, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 3 Probably 4 Whiknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Wasan autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1□ Yes or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation 1 Hatural 1 Yes 2 No efter deeth.

Director: Afi М 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours e To the Funerel C completely filled i Hospital 1 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DS7722

DHMH 17 Rev 1/2001

State Registrar

OLD COURT ROAD RANDALLSTOWN MD 21133

M.D

5401

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

M.D

LEONARD RICHARDSON

APR 1

31. Date filed (Month, Day, Year)

			1 - For State Registrar  1. Decedent's Name (First, Middle, L.	State of Ma	ıryland		artmen rtificate			and M	,	Reg. N	11116	1 1 8	3 7
	Physici		William	15()		Wiley	7				Month 4	3 Da	2006 200 Year	3. Time of 1655	Death M
	/Medic Examin		4a. Facility Name (It not institution, giver 201 N. Washing		Apt.	206		Town, or	Location o	of Death		40	c. County of Dea	ath	
ş.	Funeral Director		,	Sex 7. Age 1.[X] M 2□ F	(In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Da) 6-23	y, Year	9. Bi	rthplace (State o country) S.C.	r Foreign
	the Maryland 28e-f show	Director	10a. State 10b. County NA 10e. Street and Number			Town or Lo		Code				10a C	itizen of What C	10d. Inside Ci	
	h with		201 N. Washingto	on Street A	pt. 2	06		231				rog. o	USA	ountry :	
0000	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic svent, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Xes 2 N If Yes, Give Year or Dates:			Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecity Yes or No- Rican, etc.)		14. Race - Am Black, Wh Specify:		
7-0-1	ithin 72 ho ne. nsn "natu	Completed	15. Decedent's Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5-		(Give life.	dent's Usua kind of wor DO NOT us	k done d e retired,	ition luring most	t of works	ng		Kind of Business	·	
7 7	filed withi Hygiene. other than ent, Ire M		9th grade 17. Father's Name (First, Middle, Las	t)		Mai	ntena	nce	18 Mothe	r's Nama	(First, Middle,			urity Ad	min.
ylarid	2 should be f and Mental H is marked of raumatic ava	To Be	Raymond  19a. Informant's Name/Relationship		Wile		an Addrasa	/Ctroop to		Fran	ices			adney	
Z Z	l and 2 s Health an Im 27 is I		Mary Johnson	Daughter							imore,				
S S S	ages 1 a nt of He nt of He ror othe		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3		ce <i>n</i>	netery, cre	osition (Nan	her place	1		ate		ocation - City o		
Dairino	permit. Pages 1 Department of H Important: if its any injury or ott		4 ☐Donation 5 ☐ Other (Special Signature of Funeral Service Lice		Gar		Fore 2. Name an			4–12 y			7ings Mi e, Md.	11s, Md 21202	•
ă	Departiment of the particular		23a. Part1. Enter the disease, or con	Walter	who have	,	March				1101	E.	North A		
	Physician /Medical Examiner	Examiner	Strock, or heart failure. List onf Implediate Cause (Final dispuse or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or as a	i RA a conseque	To Nonce of): (	r F							Interval Bety Onset and I	ween Death
0/00,	cate be executed physicien and the burial-transit	dicai Exa	that initiated events resulting in death) Last	Due to (or as a	conseque	nce of):									
.O. BOX 0	death certifi e attending I id for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of the composition of the comp	2 🗌 Fetal d	eath 3[	⊒Ectopic pr ⊒ Other (sp						23d. Date of de Month		rear (ear
r V	requires that the reen signed by th hould be detache	by Pi	Part II. Other significant conditions		it not result	ing in the u	inderlying c	ause give	n in Part I.		23e. Did to	obacco	use contribute	to the cause of d	eath?
cords,	requir		CARCINON	MA LA	Ryn	Χ					1 🗆 🗅	es 2	2 No 3 F	robably 4 🗆	Jnknown
ב ב	The lay	Completed									24a. Was autop perfo 1 Yes		prior to death?		available ause of
VIE	/sicien s certif	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ★No	Hospital:	nt 2 🗆 <b>E</b> f	B/Outpatier	nt 3 DC	Othe	-		(Check only o		6 □Other (Sp	ooifu)	
5	ng Phy fter thi		27. Manner of Death 1 Anatural 5 □ Pending	28a. Date of Injur (Month, Day		8b. Time o		Bc. Injury Work			28d. Describe I			ochy)	
DIVISION	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director. After this certifical completely filled in by the funeral director,	Certification:	2 Accident investigativ 3 Suicide 6 Could not determine	be One Blace of Init	iry - At hom	e, farm, st	M reet, factory		/es 2 □ I		28f. Location (S City or Tox	Street a	and Number or F te)	Rural Route Num	ber,
-	ns Hospite n 24 hours ne Funerei sletely filled	edical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exe	hysician: To the best of miner: On the basis of and manner sta	examinatio	edge, deat n and/or in	h occurred evestigation	at the tim	e, date an pinion, dea	d place, a	and due to the ed at the time,	cause(: date ar	s) and manner and place, and du	is stated. se to the cause(s	)
	To ti withii To ti comp	Me	29b. Signature and title of certifier						number				ate signed (Mor		
	141		M To-	-E-MD		10-1 7		00	2189	19		- 4	4.4.06		
	411		30. Name and address of person who 23 SHiffins		eath (Item 2		-	2							
2000	Sta	te	31. Date filed (Month, Day, Year)	32 Registra	r's Signat	10 A	and I								

## Please Type or Print in Black Indelible Ink

riease Type of Fillit III black littlelible link	
State of Maryland / Department of Health and Mental Hygie	n

0	0	1 2	100	1	1	1	0	0
1	11	1 1		į.	ì	1	(1)	73
6.00	San P		1	1	1		101	6

Physician/
Medical Examiner
3
Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants I fileu 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physiciar /Medica Examine

Baltimore, MD 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760,

State of Maryland / Departine I- For State Certifica Registrar	ate of Death	Reg. I	2006	118
Decedent's Name (First, Middle,Last)		Date of Death     Month     Date	Voor	of Death
TANET L. WIEN	IKE	April 3, 2006	9:40	)
4a. Facility Name (if not institution, give street and number) 4622 Clairmont Mill Road	4b. City, Town, or Location of De Pylesville	ath	4c. County of Death  Harford	
5. Social Security Number 6. Sex / 7. Age (In yrs. last birth	iday) If Under 1 Year If Under 24	rs. 8. Date of Birth (N	MM/DD/YYYY) 9. Birthplace (S	State or Fore
220 - 42-668F 1 M 2VF 6/	Yrs. Months Days Hours M	Feb. 14	1945 MARY	LANL
10a. State 10b. County 10c. City, Town of	or Location		10d. Ins	ide City Lim
MAN Historial	1054:110		1 🗍	res 2 L
MA Hartord P  10e. Street and Number	ylesville 10f. Zip Code	100	Citizen of What Country?	
4622 Clairmont Mill Rd.	2 1.132	Tog.	USA	
11. Marital Status  1 Never Married 2 Married Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue</li> </ol>		14. Race - American India White, etc.	n, Black,
1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 No specify:		Specify 4)hi	te.
or Dates:	Decedent's Usual Occupation (Give kind	of work done	b. Kind of Business/Industry	
during				
10 1	most of working life. DO NOT use retired		16-	
	omemaker	mo /First Ministe Mari	at home.	
17. Father's Name (First, Middle, Last)		me (First, Middle, Maid		
Clarence L. CNSOR,	. Mailing Address (Street and Number	Margai	et unier.	
	2	1		
	PSOD Poplar Cree Disposition (Name of cemetery,	KDR. rai	oc. Location - City or Town, St	203 ate
1 Burial 2 Cremation 3 Removal from State cremato 4 Donation 5 Other Specify:	ory or other place)	4/8/06	Hydes MD	>
21. Signature of Funeral Service Licensee	22. Name and Address of Facility	FOREST	Hydes, MD HILL, MO ZIG	50.
Kunberly S. not.	EVANSFONERAL			
23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line.	t enter the mode of dying, such as cardia	c or respiratory arrest,	shock, or heart Approx	ximate Inte
Immediate Cause (Finer disease or condition resulting in death)  Multiple drug (Carbam Due to (or as a consequence of):	azepine and olanzapine)	intoxication	1	Death
Sequentially list conditions, b.				
if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
d.				
	2a-f,perME,g855,5/11/06	TT		
IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
23b. Was decedent pregnant in the	Fetal death 3 Ectopic pre	gnancy	Month Day	Year
past 12 months?  4 Pregnant at time of death 5				
1 Yes 2 V No 9 Unknown 9 Unknown				
Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause	of death?
		1 Yes	No 3 Probably 4	<b>✓</b> Unknov
		24a. Was an	24b. Were autopsy find	dings avails
		autopsy	prior to completion	
		performe 1 <b>V</b> Yes 2	d? death? No 1 ✔ Yes	2 No
25. Was case referred to medical	26.Place of Death (Che			
examiner? Hospital: 4 Innationt 3 EP/O			sidence 6 V Other Scene	
1 ✓ Yes 2 No	Time of Injury 28c. Injury at Work?	28d. Describe how		
1 Natural 5 Deading (Month, Day, Year)	1 Yes 2 V No.			
Pending   Fnd 4/3/2006 unk	I TES Z NO		gested drugs	
A Suicide Could not be	rm, street, factory, office building, etc.	28f. Location (Street	et and Number or Rural Route ) 4622 CLairmont I	Number C
4 Homicide determined (Specify) home		Pylesville	e, MD	
29a, Certifier 1 Certifying Physician: To the best of my knowledge, dea one) 2 Medical Examiner: On the basis of examination and/or in		and due to the cause(s	) and manner as started.	s)
and manner stated				
29b Sitrnature and title of certifier	29c. License number		Od Date signed (Month, Day,	rear)
( Horalelly)	O.C.M.E.	Α	pril 4, 2006	
80 Name and address of person who completed cause of death (Item 23a)				
	Penn Street, Baltimore, MD 2	1201		
31. Date filed (Month, Day, Year) 32 Registrar's Signature				
	book			
APR 1 1 2006	A STATE OF THE STA			

ORIGINAL

DHMH 17 Rev 1/2001 OCME 10/2003

Reg

			For State Registrar	State of N	Maryland		artment			and M	lental Hyg	iene	16		189
			Decedent's Name (First, Middle, I	Last)			mount	0, 2	Journ		2. Date of Deat	h		3. Time	of Death
	Physici /Medio		William	р.			Warni	ck			Month April	7. 20	Year 006	8	PM
, .	Examir		4a. Facility Name (If not institution, g		or)				Location o	f Death	прил	4c. County			
			1804 Lansing	Road			G1	en B	urnie	2		Anne	Arun	de1	
	Funeral	7	5. Social Security Number 6		Age (In yrs. las	st birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State	e or Foreign
	Director		212-22-3861	1 <b>X</b> M 2□ F	79	Yrs.	W.G.III.I	Days	110013		Jan.28,	1927	000	WV.	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation							10d. Inside	City Limite
	f sho	ŏ	MD. Anne	Arunde1	1		Burni	0							as 2XINo
	28a	rect	10e, Street and Number	nr under		GIEII	10f. Zip				1	0g. Citizen of	What Cou	nta/2	
	3a or	0	1804 Lansing Roa	d				1060				U.S.A.		, y :	
	deeth	Funeral Director	11. Marital Status	12. Was Deceder	nt Ever in U.S.	13.	Was Deced	ent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)			can Indian,	
စ္	or its	F	1 Never Married 2 Married	Armed Force: 1XXYes 2[ If Yes, Give	s? ]No		ryes, spec 1 ⊟ Yes 2	_	n, Mexican  Specify:	, Puerto	Hican, etc.)		ck, White,	etc. ite	
8	ural',	d by	3X Widowed 4 □ Divorced	Year or Dates	3:		TES 2	E INO	эреспу:			Specif	γ: W11	тсе	
2	be filed within 72 hours efter deeth with the Maryland ital Hygiene. Id other than "natural", or iteme 23a or 28a-f show event, the Medical Examinal must be published at	Completed	15. Decedent's (Specify only highest)	Education grade completed)		(Give	dent's Usua kind of wor	k done d	urina most	of worki	ng	16b. Kind of B	usiness/In	dustry	
2	withir Bne. than	E G	Elementary/Secondary (0-12)	College (1-4o	r 5+)		DO NOT us					TT 4	1		
2	Hygid Hygid Int,	ပိ	17. Father's Name (First, Middle, La	st)		Macn	ine O		-	r's Name	(First, Middle, M		ingh	ouse	
an	2 should be filed w n and Mental Hygier is marked other the reumetic event, the	To Be	William D. Warn	ick							M. Mose		,0,		
7	nd M mar	-	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a			If a Mose:	-	State. Zi	n Code)	
Baltimore, Maryland 21215-0036	es 1 end 2 should b of Health and Ment fitem 27 is marked r other traumetic		Christine Lowrim								n Burni				
ē,	of Hei	11 3	20a. Method of Disposition		20b. Plac	ce of Dispo	sition (Nam	e of			Date	20c. Location -	- City or To	own, State	
Ë	Peges nent of I ant: If its ury or o		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				ge Mei		" i	Apri 200	1 11, 6 _1	Elkride	re. M	D.	
<u>a</u>	pernit. Peges Depirtment of Important: If it any njury or o		21. Sign there of Funeral Project Lo	ensee					s of Facility	y Sin	gleton	Funeral	Hom	e. P.	Α.
m	88 5 6		Moul O	Ele_ M	School	1	Seco	nd A	venue	SW	Glen Bu	rnie, M	<b>D.</b> 2	1061	
			23a. Par 1. Enter the disease, or co shock, or heart failure. List on	mplications that causely one cause on each	IIIna	Do not ent	er the mode	of dying	, such as	cardiac c	or respiratory arre	est,		Approxim	ate etween
	Physician		Immediate Cause (Final disease or condition		e/60	2.36	na	d	1 27	as	Tota	70		Onset an	
	/Medical		resulting in death)	Due to (or a	as a conseque	nce of):	1						-	10	-
	Examiner		Sequentially list conditions.	b			- 4	ag.	2					8	cathis
0_	Pe #s	Examiner	Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a conseque	nue ul).		4							
	and and II-tran	хап	that initiated events resulting in death) Last	c	is a conseque	nce of):									
8760,	rate be executed hysicien and the burial-transit	a E		200 (0) 0	13 a consoquo	1100 01).									
89	& ₹ <del>=</del>	edical		d											
XOR	leath certifii attending p	N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom								23d Da	te of deliv	erv	
ň	death certific e attending p id for use as	Physician/Me	in the past 12 months?	4☐Pregnant	2 ☐ Fetal de at time of deat		Ectopic pre Other <i>(sp</i> e						onth	Day	Year
J.	at the de by the a	hys	9 ☐ Unknown	9∐ Unknown											
_	requires that the neen signed by th hould be detache	by Р	Part II. Other significant conditions	contributing to death	but not resulti	ing in the u	nderlying ca	use give	n in Part I.		23e. Did tob	acco use cont	ribute to t	he cause o	f death?
ğ	w require been sig should b	ed									1 □ Y6	s 2 No	3 ☐ Prot	bably 4 [	Unknown
Vital Records,	> 40	Completed									24a. Was a	n 24b.	Were auto	psy finding	s available cause of
r	The ete h page	io E									autops perform 1 Yes 2	1907	death?	2□ No	cause of
II.	Physicien: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?						26. Place	of Death	Check only on				
<u>o</u>	Physic this or	၉	1 □ Yes 2 No	Hospital: 1 ☐ Inpa	tient 2□EF	VOutpatien		and the same	4   1400	rsing Hor	ne Reside	nce 6 Oth	er (Specil	fy)	
	ding P. h. After I	Certification;	27. Manner of Death  Natural 5 ☐ Pending		Day Year)	8b. Time of Injury		3c. Injury Work			28d. Describe ho	w injury occur	red		
<u>s</u>	ten deat tor: the	cat	2 Accident investigat 3 Suicide 6 Could not	he			М		es 2 l						
DIVISION	after of Unec	틭	4 ☐ Homicide determine	289. Place of I	njury - At hometc. (Specify)	e, farm, str	eet, factory,	office			28f. Location (St. City or Town		er or Rura	al Route Nu	ımber,
_	pital		29a. Certifier 1X Certifying	Physician: To the bes	ak rof ross largerade	teles disast		a the time					COLDED CO.	F = 11	
	To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edical	(Check only 2 Medical Ex	aminer: On the basis and manner:	of examination	n and/or in	vestigation,	in my op	e, date and inion, deat	h occurr	and due to the ca ed at the time, da	ate and place,	and due t	tated. o the cause	o(s)
	To th within To th	₩ W	29b. Signature and title of certifier		/		29c.	License	number		25	9d. Date signe	d (Month,	Day, Year)	
)			Prougl !	torker	y or	0		02	-79	38	8	pril	10	200	6
	10		30. Name and address of person wi	o complyred cause of	eath (Item 2	За) (Туре,	Print)						0		
	۳ ا		Mayer G.	SUBETY	MI	7	95	A	qual	aut	R.J. (	sleal	Sura	18 Md	21061
	Sta		31. Date filed (Month, Day, Year) APR 1 1 2	GGC Regis	strar's Signatur	8	A 20 E								
	Registr	ar	WLU I I 7	UUO ASA	Red Land	A.S.	1								

	1_ For	State of Mar		artment of H		Mental Hygien	UUD.	11190
	Registrar  1. Decedent's Name (First, Middle,	Last)	Cei	lilicate of L	Jeani	Reg. N	0.	3. Time of Death
Physician		Valillian	n W/c	shins	ton Sc		S 2006	a 1
/Medical Examiner	4a. Facility Name (If not institution,	give street and number)	. 1	4b. City, Town, or	Location of Death	1 4	c. County of Deat	
	Liniversity	of Maryle	and Madicakt	e Ba	Itimo	Re	NI	A
Funeral	5. Social Security Number 6	5. Sex 7. Age (	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birtl	nplace (State or Foreign untry)
Director	£13.32.2994	10 <b>7</b> M 2□F	O Yrs.			11.07.193	5	MD
and w	Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town or Lo	cation				10d. Inside City Limits
Mary feb	MO BALTIN	NORE	WINDSOR	MILL				1 ☐ Yes 2 🗷 No
with the Markor 10 to 28a-10	10e. Street and Number			10f. Zip Code		10g. C	itizen of What Co	untry?
death with the Maryland ms 23a or 28a-f ehow routilised at neer all Director	3512 ABBIE PU	ACE		212	44		asu	
fler death v	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of Hi f Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
U36  ours after death with the Marylan rei; or Items 23s or 28s-f ehow Exercities must be notified at 1 by Funeral Director		d 1 □Yes 2 X No If Yes, Give Year or Dates:		1 □ Yes 2 🗷 No	Specify:		Specify: B1	ACK
1215-UU36 within 72 hours atter ene. than "neturel; or ite the Medical Exercibe ompleted by Fur	15. Decedent's	Education		dent's Usual Occupa		16b.	Kind of Business/	
within 72 house is within 72 house in the management of the manage	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5+)	(Give	kind of work done d DO NOT use retired,	fu <i>ring m</i> ost of wor )	king	0-0	
N BEE O	1 TH GRADE	NA	<u> </u>	ABORER			RETAIL	
© ≤ d ≅ 0 ≥	17. Father's Name (First, Middle, La	,				ne (First, Middle, Maide	n Sumame)	
aryia should ind Men in marke umatic	GEORGE WASHING		19h Mailir		ETHEL I	ral Route Number, City	or Town State 2	in Code)
Tra Tra	CHARLES WASHIN	- /-		N. ELLAMO		BALTO MO	21216	,,,,
P - 포 프 첫	20a. Method of Disposition		20b. Place of Dispo				Location - City or	Town, State
Pages Pages nent of int: If It	1 ☐ Burial 2 M Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	☐Removal from State cify)	GREENMOL	LATI	04-1	1-06 BA	TIMORE	MD
Baltimore, permit. Pages 1 a Department of Hee Important: If Item eny Injury or othe	21. Signature of Fuperal Service Lie		22	. Name and Addres	s of Facility	FUNERAL SE BAUTO. MI	DVICE	1
n ggesa	Vaughn (	)+					21229	
×3	23a. Part1. Entective disease, or conshock, or heart failure. List or	omplications that caused the nly one cause on each line.	e death. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Physician	Immediate Cause (Final disease or condition resulting in death)		mia					
/Medical Examiner	,,	6	consequence of):					
e e	Sequentially list conditions, if any, leading to immediate		consequence of):					
executed in and ial-transit	cause. Enter Underlying Cause (Disease or injury that initiated events	. Gram	negative consequence of):	Rod	infec	hion		
		Due to (or as a o	consequence of):					
B / 60 cate be e physician the buri		d			·			
X 6 Sertific ding p	IF FEMALE:	23c. If yes, outcome of	pregnancy				02d Date of dell	
P.O. BOX 60 hat the death certific d by the attending p letached for use as Physician/Mec	23b. Was decedent pregnant in the past 12 months?	1□Live birth 2 4□Pregnant at tir	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	Day Year
. 0 0 0	1 Yes 2 No 9 Unknown	9□ Unknown						
	Fait ii. Other significant condition				en in Part I.	23e. Did tobacco	use contribute to	the cause of death?
VItal Records, slcian: The law requires t certificate has been signe rector, page 2 should be Be Completed by	Renal Cell C	Cancer S	p neph	rectomy		1 🗆 Yes	2 No 3 □ Pr	obably 4 Unknown
The law require the law require page 2 should lead to the law require page 2 should lead Completed	-					24a. Was an autopsy	prior to a	topsy findings available completion of cause of
The law cete has page 2 a						performed? 1⊠Yes 2□N		2 No
Of VITAL IN Physician: The Physician: The rail director, page rail director, page Co.; To Be Co.;	examiner?	Hospital:		Othe	r	th (Check only one)		
this ald district		28a. Date of Injury	28b. Time o	I 3 DOA	4   Nursing H	ome 5 Residence		cify)
DIVISION OF I or Attending Phy atter death. Director: Atter this d in by the funeral d ertification: T.	1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day Y	rear) Injury	Work	(? Yes 2 □ No		,	
VISI Atter octor by the	3 Suicide 6 Could no	28e. Place of Injury building, etc.	/ - At home, farm, str	eet, factory, office		28f. Location (Street City or Town, Sta	and Number or Ru	ıral Route Number,
DIVISION C Lea or Attending P rs after death. al Director: Attert ed in by the funera Certification:	Tiomico	building, etc.	(Эрвспу)			Only of Yourn, Ste		
DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director. Medical Certification: To Be (	29a. Certifier 1 Certifying (Check only 2 Medical Ex	Physician: To the best of kaminer: On the basis of each	xamination and/or in					
thin 2 the on the omplet	one) 29b. Signature and title of certifier	and manner state	d.	29c. License	number	29d, E	ate signed (Monta	h, Day, Year)
F N F 8	12.+	Camer MI	$\sim$					,
^ /	30. Name and address of person w		th (Item 23a) (Type.	Print)	175610	51 ~ H	MI	1 6000
2	1		2 S. G.	reene st	Ball	hmore, m	70 21	201
State	31. Date filed (Month, Day, Year)	CAMPER 2 32. Registrar	s Signature					
Registrar	APR 1 1 2006	The Comment						

			1 - For State Registrar	State of Marylan	nd / Department of Health and Certificate of Death	Mental Hygien	
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last) Rita Washingto 4a. Facility Name (Il not institution, give s Genes [s Randallstown	OV) street and number) 7 9109 Randallst		April 0	year 7:05 PM 2006 7:05 PM 10. County of Death Baltimore County
	Funeral Director		5. Social Security Number 6. Sex 210-30-2307	7. Age (In yrs.	Ast birthday  If Under 1 Year   If Under 24 Hr   Months   Days   Hours   Mir		9. Birthplace (State or Foreign Country)  PA
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show importent: If item 27 is marked other then "naturel", or items 23e or 28e-f show any injury or other treumatic event, if a Maciful Examinar rough be notified at ance.	by Funeral Director	10a. State 10b. County  MD Baltimo  10e. Street and Number  45 Fox Run Court		Reisterstown  10f. Zip Code  21136  S.   13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue		10d. Inside City Limits  1 □ Yes 2 ☑ No  Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.
-0036	2 hours after aturel', or ite		1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Edu	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	16b.	Specify: White Kind of Business/Industry
121215-0036	led within 72 lygiene. her then "ne nt, tre Madie	Completed	(Specify only highest grade Elementary/Secondary (0-12) 10	completed) College (1-4or 5+)	(Give kind of work done during most of w life. DO NOT use retired)  Nurse's Aid	orking	Medical
Maryland	should be find Mental Himarked otl	To Be	17. Father's Name (First, Middle, Last)  Frank Lutter  19a. Informant's Name/Relationship (Ty	pe, Print)	Glad  19b. Mailing Address (Street and Number or R		
Baltimore, Ma	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importents: If item 27 is marked other then any injury or other treumatic event, If a M. ADICE.		John Whitcomb  20a. Method of Disposition  1 X Burial 2 Cremation 3 C Other (Specify)	emoval from State	59 Pheasant Ridge Ro	Date 20c.	Location - City or Town, State
Baltin	permit. P Departme importen any injury once.		21. Signature of Funeral Service License		Joseph 4/1 22. Name and Address of Facility  Eline Funeral House	11824 Re	anover, PA isterstown Road town, MD 21136
8760,	death certificate be executed  Be attending physician and a for use as the burial-transit  Compared to the com	lical Examiner	23a. Part1. Enter I. e disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence).  Due to (or as a consequence).			Approximate Interval Batween Onset and Death
.O. Box 6	that the death certifica led by the attending ph detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3 □Ectopic pregnancy	_	23d. Date of delivery Month Day Year
<b>Q</b>	sign sign	by	Part II. Other significant conditions con	ntributing to death but not res	sulting in the underlying cause given in Part I.		use contribute to the cause of death?
Il Records,	The ate h	Completed				24a. Was an autopsy performed?	
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:	Other	path (Check only one)	_
of	Phys this ral dii	10	1 Yes 2 Mo	28a. Date of Injury	EH/Outpatient 3 DOA 4 Frursing	Home 5 Residence	
Division	ttending death. ctor: After / the fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year)	Injury Work?  M 1 ☐ Yes 2 ☐ No  ome, farm, street, factory, office		and Number or Rural Route Number,
Q	To the Hospitel or A within 24 hours after To the Funerel Direction Distributed in bit of the funerel Direction by the funerel bit of the funerel	edical Cer	29a. Certifier 1 Dertifying Phys. (Check only one)	sicien: To the best of my kno	owledge, death occurred at the time, date and placation and/or investigation, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as stated. nd place, and due to the cause(s)
)	To the Howithin 24 To the Forest	Med	29b. Signature and title of certifier	mpleted cause of death (Item	29c. License number D0056414		Pate signed (Month, Day, Year) 4 - 7 - 2006
	Sta Regist	ate	Joseph El-Saye  31. Date filed (Month, Day, Year)	9 9109 Rain 32. Redistrar's Signa	dalistown Road, Rai	ndalls tow	n, MD 21133

			. For	State of Ma		d / Depa	artment	of Hea	alth and	•		•		92
			1 - State Registrar			Cei	tificate	of De	ath		Reg. N	b	1 1 1	<i>J</i> <u>L</u>
	Physici	an	Decedent's Name (First, Middle, Last	it)						2. Date of Month	Death Da	ay Year	3. Time	of Death
	/Medic	al	Sally Jo W	<i>l</i> hite						April		2006	41:1	0A M
	Examin	C!	4a. Facility Name (If not institution, give			mrr	·		cation of Dea	ith -		County of Death		
			NATIONAL INSTIT  5. Social Security Number 6. S			ast birthday)	If Undar	HESD	A Under 24 Hr		Birth	MONTGOM 9. Birth		or Foreian
	Funeral Director			□M 21X1F	68	Yrs.	Months	Days H	lours Mir	) (Month,	Day, Year	1937 III	intry) inois	e or Foreign
	<b>D</b> .		Usual Residence of Decedent											<b>0</b> 11 11 11
	arylar show	_	10a. State 10b. County			, Town or Lo							10d. Inside	es 2 No
	28a-f	Director	Maryland Montgom  10e. Street and Number	ery	Che	vy Cha	1.Se	Codo	_		100 0	itizen of What Cor		
	with the or it	ă		Codena			208					ted Stat	•	
	leath	by Funeral	4823 Wellington D	12. Was Decedent	Ever in U.	S. 13.			nic Origin?	Specify Yes or or or or or or or or or or or or or		14. Race - Amer	ican Indian,	
ယ	or iter	Ξ	1 ☐ Never Married 2 Married	Armed Forces?						erto Rican, etc.)		Black, White	, etc.	
Š	ral', c	b b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2		Specify:			Specify: Wh	ite	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. Than "netural", or tlems 23e or 28a-f show Ita Madical Examanar must be notified at	Completed	15. Decedent's Ec (Specify only highest gra	lucation de completed)		16a. Dece (Give	dent's Usua kind of wor	l Occupation	n ng most of w	orking	16b.	Kind of Business/l	ndustry	
12	within	d E	Elementary/Secondary (0-12)	College (1-4or	5+)		ic Tea				F	ducation		
g 9	filed Hygie ther	ပို	17. Father's Name (First, Middle, Last)			rius.	LC 1ea		. Mother's N	ame (First, Mide				
<u>a</u>	id be ental kad c	To Be	Eli Roeschley						Emma	Beller				
ary	shou ind M ind M ind M	-	19a. Informant's Name/Relationship (	Туре, Print)		19b. Mailir	ng Address				nber, City	or Town, State, Z	ip Code)	
Š	and 2 valth a 127 is		Donald E. White/	Husband		4823	Welli	ngton	Drive	e, Chev	y Cha	se, Mary	land	20815
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural; or Items 23e or 28a-f show any injury or other traumatic event, the Medical Examana must be notified at ange.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	C	lace of Dispo emetery, crea	matory or ot	e of her place)	Apr	il 8,	20c. l	_ocation - City or	Town, State	
Ĕ	Pag ment ant: l		* 4 □Donation 5 □ Other (Specific	y)	PIOL	tgome	ittm l	nc.	200		Bet	hesda, M	laryla	nd
쿒	Depart Depart Import any in		21. Signature of Funeral Service Licer	3		Be	Name and	Address of	Facility K	obert A ase, In	. Pum	phrey Fu 557 Wisc 1	neral onsin	Avenu
-	205 e a		23a. Part1. Entar the disease, or com	esuy.	MOO8							01	Арргохіп	
	Physician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Me Has Due to (or as	tat	ec Bruence of):	Last	L Ca	ance				Interval E Onset an	d Death
8760, <	cate be executed oblysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  Due to (or as										
P.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy page 2 should be delached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic pro				nutio.	23d. Date of deli Month	very Day	Year
Vital Records, P	puires that n signed b		Part II. Other significant conditions of	ontributing to death t	out not resi	ulting in the u	nderlying ca	ause given i	n Part I.	i		use contribute to		
000		Completed								24a. W		24b. Were au	topsy findin	gs available
æ	The la	E O								pe	utopsy erformed? s 2 🔀 N	death?	2 No	i cause of
ita	ian: rtifica	Be C	25. Was case referred to medical							eath (Check on	ly one)			
<b>&gt;</b>	hysic nis ce i direc	To E	examiner? 1 Tes 2 No	Hospital: 1 🗷 Inpati	ent 2 🗆	ER/Outpatie	nt 3□ DO	A Other:	4 Nursing	Home 5 □ R	esidence	6 ☐ Other (Spec	cify)	
0	ing Pl		27. Manner of Death 1 Sanatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time o Injury		8c. Injury at Work?		28d. Descri	be how inj	ury occurred		
Division of	or Attending Physician: fler death. birector: After this certific n by the funeral director,	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	9 ORa Blace of In			M reet, factory		2 □ No		n (Street a Town, Sta	and Number or Ru te)	ral Route N	umber,
	To the Hospitel or Attending Physician: The lav within 24 hours effect death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical Ce	29a. Certifier 1 Certifying Ph (Check only 2 Medicel Example)	nysician: To the best miner: On the basis of and manner s	of examina	wledge, deat tion and/or in	h occurred a	at the time, in my opini	date and pla on, death oc	ce, and due to to curred at the tin	he cause( ne, date a	s) and manner as nd place, and due	stated. to the caus	Θ(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	10		taff	290	. License n	umber VF	<del></del>	29d. C	ate signed (Monti	n, Day, Year	')
	->-0		Waupboth S9	Hercheski	D CI	iniciar	7	0101	102	557		4/6/0	06	
	0		30. Name and address of person who	completed cause of							1			
	1		MARYBETH S. H				enter	Dr.	-Beth	esda,	MD 2	0892		
	Sta Regist		31. Date filed (Month, Day, Year) APR 1 1 20	32 Regist			115							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend Item #5 Per FH 8854 4/Septificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Webb EdWArd 6 11:06 2006 Arence pr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltinore N/A JA(b) 4020190 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Days, (Month, Day, 5. Social Security Numb 6321 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊊**M 2□ F 73 214 30 <del>362</del> Yrs. 18, Director May Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryla Department of Health and Mantal Hyglene. Important: If Item 27 is marked other than "neturel", or Items 23a or 28e-1 show any injury or other traumatic event, Ira Medical Examinat must be notified at once. Maryland Anne Arundel 1 Yes 2 No Director Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 304 West 11th Avenue U.S. 21225 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: Korean 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 € No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Secondary (0-12) College (1-4or 5+) Mechanic Waterfront 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William L. Webb Helena Holmes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hazel Webb / wife 304 West 11th Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park 4/11/2006 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature > Funeral Şervice Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease aroom shock, or heart failure List only Immediate Cause (Final mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, y one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 3 Chays disease or condition resulting in death) epsis /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events nding physicien and resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death sate has been signed by the attraction page 2 should be detached for in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? this certificate Yes 2□ No 2 No 1 Yes : After this certifical funeral director, p 25. Was case referred to medical Be 26. Place of Death | Check only one | Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 Pending To the Flueres after death.

To the Funerel Director: Att 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number l therense pleted cau of death (Item 23a) (Type, Print) 30. Name and address of person who 79:0 Agher 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State Registrar	State of Marylar			nt of Hea <i>te of De</i>			giene Reg. No.	306	1194
	Physicia	an	Decedent's Name (First, Middle, Last)	Carol Cathele	en Will	linol	nan		2. Date of De Month	Day	Year 2006	3. Time of Death 1:50 P. M
	/Medic Examin		4a. Facility Name (If not institution, give s		C11 W111		, Town, or Loc	ation of Death	April		ounty of Death	1.50 1.
			Frederick Villa 5. Social Security Number 6. Sex			If I Inde	Catons	ville Under 24 Hrs.	2 Data of Bio		Baltimo	ore place (State or Foreign
	Funeral Director			// Age (117)/s.	Yrs.	Months		ours Min.	8. Date of Bir (Month, Da Dec. 24	y, Year) 192	Cou	rginia
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	cation						10d. Inside City Limits
	a-f eh	ctor	Virginia Howard	I	Elkridg	e						1 ☐ Yes 24 ☐ No
	h with th 23a or 26 at be no	al Director	10e. Street and Number 6391 Rowanberry	Drive Apt. 4	.09	10f. Z	ip Code 21075			10g. Citize	n of What Cou .S.	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatib and Mental Hygiene. Department: If term 27 is marked other than "naturel", or items 23a or 28a-f ehow eny injury or other traumatic event, Ita Medical Exactical natalities and page.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	I2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Deci f Yes, sp 1  Yes	ecity Cuban, M	nic Origin? (Si lexican, Puerti pecify:	pecify Yes or No o Rican, etc.)		Race - Amen Black, White, pecify: Whi	etc.
aryland 21215-0036	within 72 ho	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12th		(Give	kind of w DO NOT	ual Decupation ork done during use retired) Worker	g most of wor	king		of Business/Ir	ance Co.
and 2	d be filed y ental Hygie ced other i	To Be Co	17. Father's Name (First, Middle, Last)	C. Pirkey				Mother's Nan	ne (First, Middle Braden			
Mary	nd 2 shoul Ith and Mo 27 is marl r traumati		19a. Informant's Name/Relationship (Ty) William Willingha	ое, Print)		•			iral Route Numb	-		
ore,	ges 1 ar t of Hea if item or other		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	Place of Dispo	natory`or	other place)		Date		ation - City or T	
Baltimore,	permit. Par Departmen Important: eny injury pnce.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Juneral Service License			. Name a	and Address of	Facility G	/2006 once Fui	nera1	Service	
	80589		23a. Part1. Enter the disease, or compli	cations that caused the dea							e, Mary	1and 21225 Approximate
	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	e cause on each line.	Avoy	_	rind	des	me			Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):							
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or as a conso-	quence of):							
8760,	ficate be executed physicien and is the buriel-transit	ai Examiner	that initiated events cresulting in death) Last	Due to (or as a consec	quence of):						-	
	tificate I ig physi as the b	ledicai										
P.O. Box	To the Hospitel or Attending Physician: The law requires that the death certification 24 hours elected death.  Within 24 hours elected death.  To the Funeurs elector. After this certificete has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fett 4 ☐ Pregnant at time of 6 9 ☐ Unknown	al death 3	Ectopic   Other (s	pregnancy specify)			23	d. Date of deliv Month	ery Day Year
ds, P.	uires that t signed by id be detac		Part II. Other significant conditions con	tributing to death but not re-	sulting in the u	nderlying	cause giv <i>e</i> n in	Part I.		obacco use		the cause of death?
Division of Vital Records,	e law requir hes been si je 2 should l	Completed							24a. Was	an psy prmed?	24b. Were auto prior to co death?	opsy findings available ompletion of cause of
<u>E</u>	ding Physician: The lav h. After this certificete hes funeral director, page 2	0	25. Was case referred to medical				26.	Place of Dea	1 ☐ Yes	2) No	1 ☐ Yes	2□ No
<u>~</u>	hysicia his cer il direci	To B	TILI THIS ZISPINO	lospital: 1 Inpatient 2			Other: 4		lome 5 Res	dence 6 i		fy)
o D O	nding P tth. : After I e funera	ation:	27. Manner of Death 1 ⊠Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f M	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe	how injury	occurred	
Divis	Hospitel or Attence     A hours efter death     Funerel Director: etely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	nome, farm, str	eet, facto	ry, office		28f. Location ( City or To		Number or Rur	al Route Number,
	To the Hospitel or Attenwithin 24 hours efter deall To the Funerel Director: completely filled in by the	edical C	29a Certifying Physics (Check only one)	ner: On the bast of my kn and manner stated.	owledge deat ation and/or in	vestigation	d at the time of n, in my opinio	late and plant n, death occu	and due to the irred at the time,	causa(s) a date and p	nd manner as i lace, and due t	o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 8			D34	1907		Am.	signed (Month,	2006
*	3		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type	Print)	200	o de-to	100 Co	for	18 ms	21220
	Sta Registr		31. Date filed (Month, Day, Year)  APR 1 1 20	32. Registrar's Sign		calle	0					

Physici /Medic Examin Funeral Director	al	1. Decedent's Name (First, Middle, JAMES  4a. Facility Name (If not institution, g											
Examir Funeral Director		4a. Facility Name (If not institution,	00160	ERMA	MMA				2	Date of Death Month	Day	Year	3. Time of Death
Funeral Director										0 1	4c. County of		
Director		JOHNS HOPKINS				BAI	TIN	NORE		m D	BAU	ME	RE CITY
0			3111111	7. Age (In yrs. I	ast birthday) Yrs.	If Under		If Under 24 I	Hrs. 8 Vin.	Date of Birth (Month, Day, Feb. 21	Year)	9. Birthp	place (State or Foreigntry) yland
rd == 20		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	ocation					12333		0d. Inside City Limi
0 M	Director	Maryland Balt	imore					D	unda	alk			1 □ Yes 2 🖾 N
or 2	Oire	10e. Street and Number				10f. Zip (	Code			10	g. Citizen of W	hat Cou	ntry?
23a	a	1910 Crafton A	ve.					2	1222	2	Unite		
d within 72 hours after death with the Maryland igne. Than "natural", or Itams 23a or 28a-1 ahow the Madical Exam har must be recilled at	by Funeral	11. Marital Status  1 ☐ Never Married 22 Married  3 ☐ Widowed 4 ☐ Divorced	Armed For 1 Tyes ff Yes, Giv	2 ☑ No 'e		Was Decede If Yes, speci 1 ☐ Yes 2	rfy Cuba	spanic Origin' n, Mexican, P Specify:	? (Specif uerto Ric	ify Yes or No- can, etc.)		k, White,	can Indian, etc. White
hour		15. Decedent's	Year or Da	ates:	163 Dagg	dent's Usual	Occup	ation			6b. Kind of Bu	cinoec/lo	ducto
within ane. then "	Completed	(Specify only highest Elementary/Secondary (0-12)			(Give life.	kind of work DO NOT use	k done d e retired	during most of )	working	7			ucation
1 1 1 y	ပိ	17. Father's Name (First, Middle, La		15		. LTTII	СТРС		Name (/	First, Middle, M			deacton
be d la la la la la la la la la la la la la	8									y Gray		•	
s 1 and 2 should f Health and Mer ltam 27 is marks other traumatic	10	Frank Wiedern  19a. Informant's Name/Relationship		(141 fo)	10h Maili	an Address	/Ctroot				City or Town	State 7	- Cadal
12 st h and 7 ts r		Mrs. Irene J. W		(Wife)	1					Route Number,			
of Health Itam 27			Tederman.		1910	Craft		Ave.	Duna Dat	lalk, Ma	Oc. Location -		222
t. Page rtment o rtant: If njury or		20a. Method of Disposition  1  ☐ Burial 2  ☐ Cremation 3  4  ☐ Donation 5  ☐ Other (Spe	icity)	a   a	emetery, crei cred H	t. of	her plac Mar	y Cem.	4/1	.0/2006	Dunda	lk,	Maryland
Depa Impo Impo any i		21. Signal r J of Funeral Service Lie	censee /	man	2 44					ome of			
003 e 0		) regree	ul!	luca	4					ndalk,		nd 2	21222
		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that c nly one cause on e	aused the death ach line.	n. Do fot en	ter the mode	of dyin	g, such as car	rdiac or r	respiratory arre	st,		Approximate Interval Between Onset and Death
Physician /Medical Examiner		Immediate Cause (Finaf disease or condition resulting in death)		or as a consequ		CAN	80	NLUR	2.				2 DAYS
cete be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequ	·								
The law requires that the death certificete ite has been signed by the attending physioage 2 should be detached for use as the to	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live b	come of pregna hirth 2 Fetal lant at time of de own	death 3	□Ectopic pre					23d. Date Mor		ery Day Year
that ned b deta		Part II. Other significant condition	s contributing to de	eath but not resu	ulting in the u	inderlying ca	ause giv	en in Part I.		23e. Did tob	acco use contr	ibute to t	he cause of death?
w requires been sign should be	eted by	IscHemic		my 0 PA	THY				_	1 □ Ye			bably 4 □Unknov
	Completed	CHOLECYSTI	77.5						_	24a. Was an autopsy perform	pled? d	rior to co eath?	opsy findings availal empletion of cause of 2 No
Physiclen: this certifica ral director, p	Be	25. Was case referred to medical examiner?			1979				Death [	Check only one	)		
hysi this c	2	1 ☐ Yes 2 No	Hospital:	Inpatient 2 🗆	ER/Outpatie	nt 3 DO	A Oth	er: 4 🗆 Nursii	ng Home	e 5 🗆 Reside	nce 6 □Othe	er (Speci	fy)
	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident Investiga	tion	of fnjury th, Day Year)	28b. Time o Injury	of 28	8c. Injun Worl	yat k? Yes 2 ⊡No		3d. Describe ho	w injury occurre	ed	
or A	Certific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ad 286. Place	of fnjury - At ho ng, etc. <i>(Specif</i> )		reet, factory	, office		28	3f. Location (Str City or Town	reet and Numbe , State)	er or Rur	al Route Number,
To the Hospitel within 24 hours of To the Funeral completely filled	edical	29a. Certifier 1 Certifying (Check only ane)	Physician: To the kaminer: On the band man	best of my kno asis of examina ner stated.	wledge, deal	th occurred anvestigation,	at the tin	ne, date and p pinion, death o	occurred	nd due to the ca d at the time, da	use(s) and ma ite and place, a	nner as s and due t	stated. to the cause(s)
To the within 2 To the complet	×	29b. Signature and title of certifier	borel	2,00				20/8		29	Date signed	(Month.	Day, Year)
(5)			GIEROLE	3HOT C	OCH Zu		88	WILE	N 7	BACTIM	20e	an	
Sta Regist	200	31. Date filed (Month, Day, Year)		legistrar's Signa	ure .	lad !	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) 000 Physician a M William Anthony Yannuzzi /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number City, Town, or Location of Death Examiner timore Birthplace (State or Foreign Country) Year ff Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F 76 214-26-1569 1929 Maryland 30, Director Usual Residence of Decedent 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits fahow or other traumatic avant, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland <u>Catonsville</u> 28a-f Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Items 23a 21228 USA 1136 Baker Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [XYes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 X Never Married 2 Married 5 1 ☐ Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7;
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "na any injury or other treumatic event, Ite Madie. (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Music Director Baltimore Opera Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carmine Yannuzzi Maria Caperrelli ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1015 Nabbs Creek Road: Glen Eurnie, Maryland 21060 of Disposition (Name of Date 20c. Location - City or Town, State Paul M. Yannuzzi Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 21. Signature of Funeral Service Licenses

22. Name and Address of FacilitySterling Ashton Schwal Witzke
Funeral Home of Catonsville, Inc.
1630 Fdmondson Avenue; Catonsville, MD 21228
Approximate
Shock, or heart fail re. List only one cause on each line. 4/17/2006 Owings Mills, MD Approximate Interval Between Onset and Death Immediate Cause (Finef Coagulopalk Physician disease or condition resulting in death) /Medical Due to (or as a nsequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner burial-transit eumoma that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physicien Physician/Medicai as the IF FEMALE esn n 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9□ Unknown 9 Unknown ğ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 pg 1 Tes 2 No 3 Probably 4 Denknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 20 No 2 DNO 1 Yes 25. Was case referred to medical examiner? Be 26. Pface of Death (Check only one) Hospitaf: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To the Funeral Director: After this of completely filled in by the funeral directions. 2 1 (2) Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Maturaf 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 28f. Location (Street and Number or Rural Route Number. City or Town, State) 3 Suicide 6 ☐ Coufd not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide within 24 hours a To the Funerel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier cal and manner stated.

The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, To the Hospital or Attending Physician:

Baltimore.

State Registrar

29b. Signature and title of certifier

pbrook 31. Date filed (Month, Day, Year)

mi 32 Registrar's Signature

completed cause of death (frem 23a)

29c. License number

29d. Date signed (Month, Day, Year) 10 0

		4	For State Registrar	-	partment of Health and M ertificate of Death	lental Hygien	
1 2			Decedent's Name (First, Middle, Last)			2. Date of Death	3. Time of Death
	Physicia		-lames Y	ancer		Month Di	
	/Medic Examin		la. Facility Name (If not institution, give str	2 Conter.	4b. City, Town, or Location of Death  Bulltubre Ci	ty	c. County of Death Beltimore City
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	y) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year OCT . 13,	9. Birthplace (State or Pareign Country)
	Director		217 04 0003	1 2□ F 47 Yrs.		OCT.13,	1958 MD.
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	the Marylar 28a-f ehow	ত	MD. NA	BA	ALTIMORE		1 ☐ Yes 2 ☐ No
	r 28a	rec	10e. Street and Number		10f. Zip Code	10g. C	Citizen of What Country?
	h with 23e or	Funeral Director	1112 ANDOVER RO	AD	21218		USA
	er death w	iner	Tr. Maritar Otatos	Armed Forces?	<ol><li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li></ol>	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	72 hours after death with the Maryland ineturel', or Items 23e or 28s-f ehow dical Exeminer must be notified at	by Fu	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give X Year or Dates:	1 ☐ Yes 2 ☐ Xo Specify:		Specify: BLACK
5-0036	"neturel",	ed	15. Decedent's Educa	tion 16a. De	cedent's Usual Occupation	16b.	Kind of Business/Industry
215	nin 72	Completed	(Specify only highest grade of Elementary/Secondary (0-12)	Completed) (G life College (1-4or 5+)	ive kind of work done during most of work a. DO NOT use retired)	ing	
2121	d within giene.	E O	9TH	MOM			FFICE RELOCATOR
nd	12 should be filed within 7 n and Mental Hygiene. 7 le marked other than " freumatic event, Ite Med	Be	17. Father's Name (First, Middle, Last)			e (First, Middle, Maide	en Sumame)
<u>yla</u>	ould Men Marke vatic	ဥ	JAMES YANCEY S		ELLE ailing Address (Street and Number or Rur	N BRUSON	or Town State Zin Code)
Maryland	12 sh h and 7 le m treum		19a. Informant's Name/Relationship (Type	- area			
-	s 1 and 2 should be filed within 72 hours after death with the Maryla if Health and Mental Hygiene. Item 27 Is marked other than "neturel", or Items 23e or 28e-f eho other treumatic event, the Modical Expraner must be notified at		LORETTA GARDNER 3  20a. Method of Disposition	20b. Place of Di	Sposition (Name of prematory or other place)	ALTO, MD. Date 20c.	Location - City or Town, State
Baltimore	0 0 = =		1 ☑ Burial 2 ☐ Cremation 3 ☐ Rel 4 ☐ Donation 5 ☐ Other (Specify)	noval from State		14 2006 1	BALTO,MD.
atti	permit. Pag Depertment Important: I eny injury o		21. Synature of Funeral Service Licenses		22. Name and Address of Facility CALVIN B. SCRUG	CS FINER	AI. HOME
m	Depermine on in in in in in in in in in in in in in		Dunadne	Acus	1412 E. PRESTON	ST. BAL	ro.MD. 21213
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the death. Do not cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	ASCUD			0,100,110,000
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):			
	37 p	ē	Sequentially list conditions, b.	Due to (or as a consequence of):			
$\sqrt{I}$	uted I Insit	를	cause. Enter Underlying Cause (Disease or injury				
۸,	be executed sician and burial-transit	Examin	that initiated events c. resulting in death) Last	Due to (or as a consequence of):			
8760	cate be ex physician the buria	dlcal	d.				
9	entifica ling pl	Med	IF FEMALE:	. If we auteeme of erogenmon			32d Date of delivery
Вох	death certifics e attending pl ed for use as t	Physician/Me	23b. Was decedent pregnant in the past 12 months?	c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death  4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery  Month Day Year
o.	0 0 0	yslo	1 ☐ Yes 2 <b>©</b> No 9 ☐ Unknown	9 Unknown	3 Gillot (Speechy)		
<u>a</u>	requires that the leen signed by th hould be detache	by Pr	Part II. Other significant conditions cont	ributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
rds	w requires been sig should be	ed b				1 🗆 Yes	2 No 3 Probably 4 dunknown
ဝ၁	aw Lish	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
œ.	The ate h page	E O				performed' 1 ☐ Yes 2 ☐	
/ita	ılcian: Th certificate rector, paç	Be	25. Was case referred to medical examiner?	anitali x 0	26. Place of Dea	th (Check only one)	
of	Physician: r this certific ral director,	5	1 ☐ Yes 2☐ No  27. Manner of Death	espital: 1 ☐ Inpatient	itient 3 DOA 4 Nuising H	ome 5 Residence 28d. Describe how in	6 ☐ Other (Specify)
uo	15 e	tlon	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Tim (Month, Day Year)	ry Work? M 1 ☐ Yes 2 ☐ No		
Division of Vital Records,	Attending r death.	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm	, street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number,
á	s after of Dire	Certification:	4   Homicide	building, etc. (Specify)		ony or rown, or	
	To the Hospitel or Attendit within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	cian: To the best of my knowledge, of: On the basis of examination and/of and manner stated.	feath occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
			1 Inthe	MD	D0081591	4	1-8-06.
	6		30. Name and address of person who cor	npleted cause of death (Item 23a) (T	(pe Print)	dieto M	f-8-06.
	7		31. Date filed (Month, Day, Year)	32. Registrar's Signature	1 mu Bach	mece P	
	St Regist	ate trar	ΔPR 1 1 200	10	South		

DHMH 17 Rev 1/2001

ORIGINAL

		•	For State Registrar	State of	Marylan	•		nt of Ho te of E		and Mo	ental Hyg	iene g. No.	06	-	98
			1. Decedent's Name (First, Middle,	Last)		-					2. Date of Deat Month	h Day	Year	3. Time of	Death
	Physicia /Medic		Isabelle	France	s	Allard	l				March		2006	9:50	P <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution,	-				, Town, or	Location o	of Death		1	ounty of Death		
			BERLIN NURSING &	REHABILI	TATION	CENTER		BERI					ORCESTI		
	Funeral			6. Sex 1 ☐ M 2 ☐ <b>X</b> F	7. Age (In yrs.		If Unde Months	or 1 Year Days	If Under :	24 Hrs. Min.	8. Date of Birth (Month, Day, 2/23/19	Year)	9. Birth	olace (State o	r Foreign
н	Director		214–18–9350	10 W 2034	83	Yrs.					2/23/19	23	Ma	aryland	<u> </u>
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. Inside Ci	ty Limits
	aryli eho	5	Maryland Wicom	ni co		Salisbu	irv							1 <b>∑</b> Yes	2 🔲 No
	the A	Directo	10e. Street and Number	1100		DULLEDO		ip Code			1	Og. Citizer	n of What Cou	ntry?	
	with o	ã	1707 Eastgate	Drive				2180	24				USA		
	na 23	Funerai	11. Marital Status	12. Was Dece	edent Ever in U	I.S. 13. V	Was Dec	edent of Hi	spanic Ori	gin? (Spe	city Yes or No-		Race - Ameri		
<b>'</b>	fler o	ᇤ	1 Never Married 2 Marrie	Armed Fo ad 1 ☐ Yes	2 XNo					i, Puerto i	Rican, etc.)		Black, White,		
ဗ္ဗ	ef', o	by	3 XWidowed 4 ☐ Divorced	If Yes, Giv Year or D	re ates:		1 🗌 Yes	2121110	Specify:			Sp	pecify: W	nite	
က်	72 ho	Completed	15. Decedent' (Specify only highes	s Education		16a. Deced	kind of w	ork done a	turing most	t of workir		16b. Kind	of Business/Ir	dustry	
7	ithin	npie	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. L	DO NOT	use retired,	)			D	usines	<b>-</b>	
7	ygier ygier ther th	S	12			DOOR	kkeer	)er	10 Marks	de Nomo	(First, Middle, I				
밀	tal H off	Be	17. Father's Name (First, Middle, L Francis Holtma								e Stuler		irriamo)		
3	d Mer narke	2	19a. Informant's Name/Relationsh			10h Mailin	a Addro	ec (Stroot a	and Numbe	ar or Rum	l Route Number	City or T	own State Zi	n Code)	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or itema 28s or 28s-f show important: if Item 27 is marked other than "naturel", or itema 28s or 28s-f show important: if item 27 is marked other than "page".  Date:	0.0	Veronica Jones/				-				clin, MI			,	
o,	1 an Heall Gern 2		20a. Method of Disposition		20b. I	Place of Dispo	sition (N	ame of	- 1				tion - City or T	own, State	
2	ages int of t: # if		1 ☐ Burial 2 【XCremation 4 ☐ Donation 5 ☐ Other (Sp		State	cemetery, cren lisbury	•			3/23,	/06	Sali	sbury,	MD	
Baltimore,	artme ortan injur		21 Signature of Funeral Service L		Da.										ation
Ba	Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen		1 186:00	Domos	TO CF	SP	501	Snow	Hill	Rd.	Home Pro , Salisk	oury,	MD 21	304	201011
			23a. Part1. Enter the disease, or	complications that of	aused the dea		er the m	de of dyin	g, such as	cardiac o	r respiratory arr	est,		Approximat Interval Bet	.e ween
	Physician		shock, or heart failure. List of Immediate Cause (Final		hersel	la Li	Ca	dia	Mr. Canl	100	Discort		]	Onset and	
	/Medical		disease or condition resulting in death)		(or as a consec		Cu.	ouco	urcen		- 13000			1 00	117
	Examiner		Comments the ties are distance	b											
	B #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a consec	quence of):									
	ocuted nd trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с											
Ö,	ate be executed hysicien and the burial-transit	Ě	resulting in death) cast	Due to	(or as a consec	quence or):									
8760,	icate be executed physicien and s the burial-transit	Physician/Medicai		d				-							
9	daath certific e attending p id for use as	Me	IF FEMALE:	23c If yes out	tcome of pregn	ancy						22	d. Date of delik	· · · · · · · · · · · · · · · · · · ·	
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1☐Live b	oirth 2 Fet	al death 3	Ectopic Other (	pregnancy				23	Month	•	Year
	the da by the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkn		004111 52	J Olliot (	эрвопу)							
P.0	that the da led by the a detached f	F.	Part II. Other significant condition	ns contributing to d	eath but not re	sulting in the u	nderlying	cause give	en in Part I	l.	23e. Did to	bacco use	contribute to	the cause of o	death?
ds	8 50	d by									1 🗆 Y	es 2 🗆	No 3□Pro	bably 4	Unknown
S	> 0 0	Completed									24a. Was a	ın	24b. Were aut	opsy findings	available
Re	0 - 6	Ę									autopa	med?	prior to c death? 1 ☐ Yes	ompletion of a	ause of
a	ician: Th certificate rector, pag	ပိ	25. Was case referred to medical					_	26 Place	e of Death	1 Yes 1	No No	1 103	20140	
5	Physician: this certific ral director,	To B	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 🗆 I	Oth	an Ø		ne 5□Resid		☐Other (Spec	ify)	
9	g Ph er thi		27. Manner of Death	28a. Date	of Injury th, Day Year)	28b. Time o Injury	ıf	28c. injun World	y at	:	28d. Describe h	ow injury	occurred		
<u>ö</u>	Attending r death. ector: After oy the fune	atio	1 Natural 5 Pendin 2 Accident investig	jation	, 52) 102.	,,	М		Yes 2	No					
Division of Vital Records,	r Atts ter de irecto	ertification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	inad 286. Place	of Injury - At I	nome, farm, sti	reet, fact	ory, office			28f. Location (S City or Tow	treet and i	Number or Ru	ral Route Nun	nber,
۵	- C # C	O													
	Hospital 24 hours Funeral stely filled	edical	(Check only 2 Medical	g Physician: To the be Examiner: On the b	asis of examin	nowledge, deat lation and/or in	h occurre ve <i>s</i> tigati	ed at the tin	ne, date ar pinion, dea	nd place, a	and due to the o ed at the time, o	ause(s) a late and p	nd manner as lace, and due	stated. to the cause(:	s)
	within 24	Med	one)		nner stated.			9c. Licens					signed (Month		
	るができ		29b. Signature and title of certifie		8 ,	. 7		-	) (7)	10	, '	- 1	/	-	
	13		11/10	marches	un		Divi	0	100	161		ノ(	00	~	
	1/2		30. Name and address of person	wno completed cau	se of death (Ite	em 23a) (Type,	(2	39 (	eask	-1	Acol.	170	231	Island	0049
	C	ate	31. Date filed (Month, Day, Year)	32.	gistrar's Sign	nature	4	, ,		-4	Jamy	, , , ,		i mey	~ (
	Pagist		MAR 2	4 2006	9.00.00	KA	6000	9			I				

DHMH 17 Rev 1/2001

Allard, Isabelle A.

			1 - For State Registrar	State of Maryla	nd / Depa		Health a	ind Mental I		9 0 6	11199
	hysicia /Medic Examin	cal	Decedent's Name (First, Middle, Last)     John Hammer Alex.  4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town		2. Date o Month March f Death	25, Da	2006 c. County of Death	3. Time of Death 0354
Dir	ineral rector		Union Hospital o  5. Social Security Number 218-03-7037  Usual Residence of Decedent		L y last birthday) Yrs.	Elkton If Under 1 Yes Months Day	ar If Under:	Min. (Month	f Birth , Day, Year	Cecil 9. Birth Con 1919 Mar	place (State or Foreign intry) yland
ith the Maryland	or 28a-f show se notified at	Director	10a. State 10b. County Maryland Cecil 10e. Street and Number	No	ity, Town or Lo	10f. Zip Code			10g. C	itizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 📉 No untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene.	ai', or items 23a Evaniner musik	by Funeral Director	11. Marital Status  1 Never Married  Married 3 Widowed 4 Divorced	delphia Road  2. Was Decedent Ever in the Armed Forces?  1	1	2190 Was Decedent of If Yes, specify C	of Hispanic Ori uban, Mexican	gin? (Specify Yes o , Puerto Rican, etc.		ted Stat  14. Race - Amer Black, White  Specify: Whi	ican Indian, , etc.
iled within 72 ho dygiene.	ther then "natur nt. It e Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		(Give	dent's Usual Occ kind of work do DO NOT use ret	ne during most ired)	of working t's Name (First, Mi	Home	Kind of Business/l  Buildi  Sumame)	·
d 2 should be fill th and Mental Hy	7 is marked of treumatic ever	To Be	David Alexander  19a. Informant's Name/Relationship (Tyx Eleanor Alexander/			-	Susie	unknow	n) umber, City	or Town, State, Z	ip Code) t, MD 21901
Definition of Health	rtent: if item 2 njury or other i		20a. Method of Disposition  1 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	20b. emoval from State	Place of Dispo cemetery, crei orth Ea Ceme	osition (Name of matory or other p st Meth tery	odist 1	March 28, 2006 Crouch	Nort	ocation - City or the East,	
Dega Dega Dega Dega Dega Dega Dega Dega	fmpo any ir once.		23a. Part1. Entyr the disease, or complice shock, or hard failure. List only on		12	7 South	Main 5	St., Nort	h East		Approximate Interval Between Onset and Death
/Me Exam	hysicien and edical miner transit the burial-transit	ilcal Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Ethar lind anying Cause (Disease or injury that initiated events resulting in death) Last	Due to ((r as a conse	equence of):	iser					
the death certificate	the ettending phy ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ac. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fel 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3[	□Ectopic pregna □ Other (specify)			_	23d. Date of deli Month	very Day Year
he law requires that the	been signed by the ette should be detached for	by	Part II. Other significant conditions con	_	esulting in the u	inderlying cause	given in Part I.			2 □ No 3 □ Pro	the cause of death?  bbably 4 &Unknown  topsy findings available
Physicien: The law	is certificate has director, page 2:	Be Completed	25. Was case referred to medical examiner?	ospital:			Othorn	1 ☐ Y		o 1 Yes	empletion of cause of
- A		cation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	⊒ ER/Outpatier 28b. Time o Injury	of 28c. Ir	njury at Vork?	No	ribe how înji	ury occurred	
TOTSION OF TOTHS HOSPITAL OF Attending Plantin 24 hours after death.	nerei Director: After th / filled in by the funeral	ai Certification;	3 Suicide 6 Could not be determined  29a. Certifier 1 Certifying Phys	28e. Place of Injury - At building, etc. (Spec ician: To the best of my kr	cify)	h occurred at the	e time, date an	City o	r Town, Sta	s) and manner as	ral Route Number,
To the Ho within 24 h	To the Fu completely	Medicai	29b. Signature and title of certifier	er: On the basis of examirand manner stated.	nation and/or in	29c. Lice	ense number	th occurred at the t	ime, date ar	ate signed (Montl	n, Day, Year)
	Sta Registr		30. Name and address of person who co  JUI CHIH #SV  31. Date filed (Month, Day, Year)  MAR 2 9 2006	mpleted cause of death (lite	am 23a) (Type, 2 2 3 M naydre	Print)	an st	EIGH	2 X	1d 21	921

State of Maryland / Department of Health and Mental Hygiene 116

THEODORE AUTRY  19a. Informant's Name (First, Middle, Last)  THEODORE AUTRY  19b. Mailing Address (Street and Number of Paul Route Number, City or Town, State, Zip Code)  TANKERMAN  TUGBOAT  10  17. Father's Name (First, Middle, Maiden Sumame)  THEODORE AUTRY  19a. Informant's Name(First, Middle, Last)  THEODORE AUTRY  19a. Informant's Name(First, Middle, Last)  THEODORE AUTRY  19b. Mailing Address (Street and Number of Paul Route Number, City or Town, State, Zip Code)  TANKERMAN  TUGBOAT  10. TOWN, State, Zip Code)  TANKERMAN  TUGBOAT  11. Father's Name (First, Middle, Maiden Sumame)  THEODORE AUTRY  19a. Informant's Name(First, Middle, Last)  THEODORE AUTRY  19a. Informant's Name(First, Middle, Last)  THEODORE AUTRY  19b. Mailing Address (Street and Number of Paul Route Number, City or Town, State, Zip Code)  TANKERMAN  TUGBOAT  10  17. Father's Name (First, Middle, Maiden Sumame)  THEODORE AUTRY  19b. Mailing Address (Street and Number of Paul Route Number, City or Town, State, Zip Code)  TANKERMAN  TUGBOAT  10  17. Father's Name (First, Middle, Maiden Sumame)  THEODORE AUTRY  19a. Informant's Name(First, Middle, Last)  TANKERMAN  TUGBOAT  18. Mother's Name (First, Middle, Maiden Sumame)  THEODORE AUTRY  19a. Informant's Name(First, Middle, Last)  TANKERMAN  TUGBOAT  11. Tankers name (First, Middle, Maiden Sumame)  The Double Number of Paul Route Number, City or Town, State, Zip Code)  TANKERMAN  TUGBOAT  19a. Tankers name (First, Middle, Maiden Sumame)  The Double Number of Paul Route Number, City or Town, State, Zip Code)  Tankers and Number of Paul Route Number, City or Town, State, Zip Code)  Tankers name (First, Middle, Maiden Sumame)  The Double Number of Paul Route Number, City or Town, State, Zip Code)  Tankers name (First, Middle, Maiden Sumame)  Tankers name (First, Middle, Mai						Ce	rtificate of	Death		Reg. No.	U	Long	
ESTINITION  As Facility Name of forestiment proposation and past and managed of the proposation of the propo	T			1. Decedent's Name (First, Middle, Last)							Vear	3. Time	of Death
A LICE BYTO TAMES NUMBERS IN HOME  FUNDING TO THE PROPERTY OF				COLBOURNE	HENRY	AUTF	?Y		03	24 20	006	8:30	O PM
Social Security Number   1.5 social Securit	'i y			4a. Facility Name (If not institution, give s	treet and number)			4b. City, Town, or	Location of Death	4c. County	of Death		
Purpose   Company   Comp	,			ALICE BYRD TAWES	NURSING HO	ME		CRISFI	ELD	SOME	ERSET		
The County of th	T	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthday			(Month. Da	v. Year)	9. Birthple Count	ace (Statery)	e or Foreign
TOS. SPAN TO COMPACK  TOS. Space and Number  TOS. Decoders from the Country  TOS. Space and Number  TOS. Decoders from the Country  TOS. Space and Number  TOS. Space  TOS. Space and Number  TOS. Space and N		Director		220-30-5185	7	9 Yrs.			11/22/	1926	VIRG	INIA	
DEAN PARKS AUTRY/SPOUSE  20b. Mercod of Disposition 11 Quarter 12 Clowardians 21 September 12 Clowardians 22 Supplication 12 Clowardians 22 Supplication 12 Clowardians 23 Supplication 12 Clowardians 24 Clowardians 25 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 25 Supplication 12 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12		pur *			100	City. Town or I	ocation				10	d Inside	City Limits
DEAN PARKS AUTRY/SPOUSE  20b. Mercod of Disposition 11 Quarter 12 Clowardians 21 September 12 Clowardians 22 Supplication 12 Clowardians 22 Supplication 12 Clowardians 23 Supplication 12 Clowardians 24 Clowardians 25 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 25 Supplication 12 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12		sho	ъ	·									
DEAN PARKS AUTRY/SPOUSE  20b. Mercod of Disposition 11 Quarter 12 Clowardians 21 September 12 Clowardians 22 Supplication 12 Clowardians 22 Supplication 12 Clowardians 23 Supplication 12 Clowardians 24 Clowardians 25 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 25 Supplication 12 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12		the N	ect			TANGI				10g Citizen of V	Vhat Count	n/2	
DEAN PARKS AUTRY/SPOUSE  20b. Mercod of Disposition 11 Quarter 12 Clowardians 21 September 12 Clowardians 22 Supplication 12 Clowardians 22 Supplication 12 Clowardians 23 Supplication 12 Clowardians 24 Clowardians 25 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 25 Supplication 12 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12		with be or						)				.,.	
DEAN PARKS AUTRY/SPOUSE  20b. Mercod of Disposition 11 Quarter 12 Clowardians 21 September 12 Clowardians 22 Supplication 12 Clowardians 22 Supplication 12 Clowardians 23 Supplication 12 Clowardians 24 Clowardians 25 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 25 Supplication 12 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12		leath	era		2. Was Decedent Ever	in U.S. 13.			Specify Yes or No			an Indian	
DEAN PARKS AUTRY/SPOUSE  20b. Mercod of Disposition 11 Quarter 12 Clowardians 21 September 12 Clowardians 22 Supplication 12 Clowardians 22 Supplication 12 Clowardians 23 Supplication 12 Clowardians 24 Clowardians 25 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 25 Supplication 12 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12	_	r iter	핊		Armed Forces?				to Rican, etc.)	Blac	k, White, e	itc.	
DEAN PARKS AUTRY/SPOUSE  20b. Mercod of Disposition 11 Quarter 12 Clowardians 21 September 12 Clowardians 22 Supplication 12 Clowardians 22 Supplication 12 Clowardians 23 Supplication 12 Clowardians 24 Clowardians 25 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 25 Supplication 12 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12	2	urs e	δ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: U.S	. ARMY	1 LiYes 2 KNNO	Specify:		Specify	. MHIJ	E	
DEAN PARKS AUTRY/SPOUSE  20b. Mercod of Disposition 11 Quarter 12 Clowardians 21 September 12 Clowardians 22 Supplication 12 Clowardians 22 Supplication 12 Clowardians 23 Supplication 12 Clowardians 24 Clowardians 25 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 25 Supplication 12 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12	2	72 ho	ted	15. Decedent's Educ	cation	/Givi	a kind of work done	a durina most of wo	rkina	16b. Kind of Bu	siness/Ind	ustry	
DEAN PARKS AUTRY/SPOUSE  20b. Mercod of Disposition 11 Quarter 12 Clowardians 21 September 12 Clowardians 22 Supplication 12 Clowardians 22 Supplication 12 Clowardians 23 Supplication 12 Clowardians 24 Clowardians 25 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 25 Supplication 12 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12	7	ithin	agu.			life.	DO NOT use retire	90)	3				
DEAN PARKS AUTRY/SPOUSE  20b. Mercod of Disposition 11 Quarter 12 Clowardians 21 September 12 Clowardians 22 Supplication 12 Clowardians 22 Supplication 12 Clowardians 23 Supplication 12 Clowardians 24 Clowardians 25 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 25 Supplication 12 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12	7	ed w ygier fer th	ပ်				TANKER		(Fi ) Sid-H-				
DEAN PARKS AUTRY/SPOUSE  20b. Mercod of Disposition 11 Quarter 12 Clowardians 21 September 12 Clowardians 22 Supplication 12 Clowardians 22 Supplication 12 Clowardians 23 Supplication 12 Clowardians 24 Clowardians 25 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 25 Supplication 12 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12		be fil d oth	Be								16)		
DEAN PARKS AUTRY/SPOUSE  20b. Mercod of Disposition 11 Quarter 12 Clowardians 21 September 12 Clowardians 22 Supplication 12 Clowardians 22 Supplication 12 Clowardians 23 Supplication 12 Clowardians 24 Clowardians 25 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 20 Supplication 12 Clowardians 25 Supplication 12 Supplication 12 Clowardians 26 Supplication 12 Clowardians 27 Supplication 12 Clowardians 28 Supplication 12 Clowardians 29 Supplication 12 Clowardians 20 Supplication 12	Š	ould Merke Marke	မ					-				0.41	
Description of the property of	<u> </u>	C/ w w w					( 50 P)						
Description of the property of	a)	1 and Healt em 2				1513; b. Place of Disp	2 MAIN ST osition (Name of	P.O.		TANGIE	City or Tox	234 vn. State	40
Physician Medical Examinor  1	ĕ	ages or o		1 Burial 2 □ Cremation 3 □ R	emoval from State	cemetery, cre	ematory or other pla						
Physician Medical Examinor  1		it. Partrant							03/28/06	TANGIER	, VIF	(GIM	[A
Physician Modical Examiner  Page 19 July 19 Ju	ם	Depa Impo any i		21. Signature 4 Full dual Service License	1.11-								
Physician (Medical Examiner)    Part				AUMI J. U	Mkan								
Physician Medical Examiner    Part II Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.				shock, or heart failure. List only on	cations that caused the d e cause on each line.	death. Do not er	iter the mode of dy	ing, such as cardia	c or respiratory a	rrest,	1	Interval E	Between
Due to (or as a consequence of):    Sequence of the control of the	,			Immediate Cause (Final		)	11.0						
Sequenciary list conditions, and property of the property of t				disease or condition				) (					
Cause (Disease or injury training in death) Last  Due to (or as a consequence of):  Cause (Disease or injury training in death) Last  Due to (or as a consequence of):  Cause (Disease or injury training in death) Last  Due to (or as a consequence of):  Cause (Disease or injury training in death) Last  Cause (Disease or injury training in death) Last  Due to (or as a consequence of):  Cause (Disease or injury training in death) Last  Due to (or as a consequence of):  Cause (Disease or injury training in death) Last  Cause (Disease or injury to death but not resulting in the underlying cause given in Part I.  Cause (Disease or injury to death but not resulting in the underlying cause given in Part I.  Cause (Disease or injury to death)  Cause			e		Due	to (or as a conse	quence of):				1		
Cause (Disease or injury training in death) Last  Due to (or as a consequence of):  Cause (Disease or injury training in death) Last  Due to (or as a consequence of):  Cause (Disease or injury training in death) Last  Due to (or as a consequence of):  Cause (Disease or injury training in death) Last  Cause (Disease or injury training in death) Last  Due to (or as a consequence of):  Cause (Disease or injury training in death) Last  Due to (or as a consequence of):  Cause (Disease or injury training in death) Last  Cause (Disease or injury to death but not resulting in the underlying cause given in Part I.  Cause (Disease or injury to death but not resulting in the underlying cause given in Part I.  Cause (Disease or injury to death)  Cause		uted d ensit	m.	Sequentially list conditions b	. Due	lu lui da a cunst	iduance offi.						
Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.    1	Ď	exec an an riel-tr	Exa	if any, leading to immediate cause. Enter Underlying	240	(0. 20 2 20	.,						
Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.    1	9	ite be iysicii he bu	ical	that initiated events	. Due t	o (or as a conse	quence of):						
Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.    1	ĕ	ng ph	Ned Med	resulting in death) Last									
1   Yes 2   No 3   Probably 4   Unknown    24a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?  1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 1   Yes 2   No 2   Yes    25. Was case referred to medical evaluation of death?  1   Yes 2   No 2   Yes   õ	S P S												
24a. Was an autopsy findings available prior to completion of cause of death?  1   Yes   2   No    25. Was case referred to medical examiner?  16. Yes   2   No    25. Was case referred to medical examiner?  16. Yes   2   No    26. Place of Death (Check only one)  27. Manger of Death   Yoursing Home   5   Residence   6   Other (Specify)  28b. Date of Injury   M   1   Yes   2   No    27. Manger of Death   Yoursing Home   5   Residence   6   Other (Specify)  28b. Date of Injury   M   1   Yes   2   No    27. Manger of Death   Yoursing Home   5   Residence   6   Other (Specify)  28b. Date of Injury   M   1   Yes   2   No    27. Manger of Death   Yoursing Home   5   Residence   6   Other (Specify)  28b. Date of Injury   M   Yes   2   No    28c. Injury   M   Yes   2   No    28c. Injury   M   Yes   2   No    28d. Location (Street and Number or Rural Route Number, City or Town, State)  28c. Injury   M   Yes   2   No    28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Date signed (Month, Day, Year)	-	e dea the at	sic	Part II. Other algnificant conditions con	tributing to death but not	resulting in the	underlying cause g	iven in Part I.	23b. Did	tobacco use co	ntribute to	the caus	e of death?
The set of set o	Ţ.	d by							1 🗆	Yea 2□ No	3 🗌 Prob	ably 4	Unknown
The set of set o	Š,	res the signe	by						04- 14/		24h Wo	re autoni	ev findings
The set of set o	5	requi	etec						perfo	rmed?	ava	ilable prid	or to
28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Death (Check only one)  28. Place of Injury of Inj	<u> </u>	has be 2 s	ηdμ								of d	eath?	
27. Manner of Death Natural Suicide Accident Suicide All Homicide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?  1 Yes 2 No  28d. Describe how injury occurred  28d. Des	<u></u>	: The cate	ខ						1 🗆 '	Yes 2 XNo	1 🗆	Yes 2	!□ No
27. Manner of Death Natural Suicide Accident Suicide All Homicide  28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?  1 Yes 2 No  28d. Describe how injury occurred  28d. Des		ician Sertifi Pector		examiner?	ospital:		_ 0						
The state of the s	5	cal dir		TE TOS ZERINO	1 L Inpatient		ent 3LI DOA	4 Nursing I				)	
The state of the s		fing I	lon	Natural 5 ☐ Pending	(Month, Day Yea	r) Injury	Wo	ork?	Edd. Booking	now anjury occur.			
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Signature and title of certifier  29b. Signature and didress of person who completed cause of death (Item 23a) (Type, Print)  VIJAY KARUMBUNATHAN M.D., 201 HALL HWY., CRISFIELD, MARYLAND	2	deatl deatl ctor: y the	lca	3 Suicide 6 Could not be	28e. Place of Injury -	At home, farm, s			28f. Location (	Street and Numb	er or Rural	Route N	lumber,
30. Name end address of person who completed cause of death (Item 23a) (Type, Print)  VIJAY KARUMBUNATHAN M.D., 201 HALL HWY., CRISFIELD, MARYLAND	<u> </u>	or A efter Direct	ert	4 Homicide	building, etc. (Sp	ecify)	,,		City or To	wn, State)			
30. Name end address of person who completed cause of death (Item 23a) (Type, Print)  VIJAY KARUMBUNATHAN M.D., 201 HALL HWY., CRISFIELD, MARYLAND		spita nours nerel		29a. Certifier 1 Certifying Phys	icien: To the best of my	knowledge, dea	th occurred at the t	time, date and place	e, and due to the	cause(s) and ma	inner as st	ated.	
30. Name end address of person who completed cause of death (Item 23a) (Type, Print)  VIJAY KARUMBUNATHAN M.D., 201 HALL HWY., CRISFIELD, MARYLAND		e Hoo 24 h e Fur	dic	(Check only 2 Medical Exemination)	er: On the basis of exar and manner stated.	nination and/or in	nvestigation, in my	opinion, death occ	urred at the time,	date and place,	and due to	the caus	e(s)
30. Name end address of person who completed cause of death (Item 23a) (Type, Print)  VIJAY KARUMBUNATHAN M.D., 201 HALL HWY., CRISFIELD, MARYLAND		To the within To the Somp	Me	29b. Signature and title of certifier	,		29c. Licen	nse number		29d. Date signe	d (Month, L	Jay, Year	7)
VIJAY KARUMBUNATHAN M.D., 201 HALL HWY., CRISFIELD, MARYLAND					1-9		D	48098		3/2	25/2	006	
VIJAY KARUMBUNATHAN M.D., 201 HALL HWY., CRISFIELD, MARYLAND  State Registrar  WAR 2 7 2006  State Registrar	•			30. Name end address of person who co	mpleted cause of death	(Item 23a) (Type	, Print)						
State Registrar  31. Date filed (Month, Day, Year)  MAR 2 7 2006  32. Registrar's Signature		, ep = . c = . c		VIJAY KARUMBUNATHAN M	.D., 201 HALL	HWY., CF	RISFIELD, M	ARYLAND					
Hegistral Minit N ( 2000 ) States & States				31. Date filed (Month, Day, Year)  MAD 9 7 7	32. Regionar's S	ignature	1 .						
DHMH 16 Day 606			- 19	mru a ( L	The state of	2 10.	A TONE						

			For State Registrar	State of M	faryland		artment rtificate			and M		giene	6 1	1201
	Dhusisi		1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medio		ROBERT REED BA	UER							March			12:03 p <sup>M</sup>
	Examir	ıer	4a. Facility Name (If not institution,	give street and number	7)		4b. City, To	own, or t	Location of	f Death			nty of Death	
			7301 Good Luck  5. Social Security Number		ge (In yrs. las	et hiethday)	New If Under 1	Car	roll		O Date of Bird			eorge's
	Funeral Director		577-28-7339	1MM 2□F	84	Yrs.		Days	Hours	Min.	8. Date of Birtl (Month, Day Sept. 2	, Year)	Cou	place (State or Foreign ntry) t Virginia
			Usual Residence of Decedent								bept. Z	7, 1721	. WES	c viiginia
4	ehow		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
2	8a-1-6	Director		George's	New	Carr	ollton							1 X Yes 2 ☐ No
į	or 2	Dire	10e. Street and Number	D 1			10f. Zip C					10g. Citizen o		ntry?
4	18 23.	erai	7301 Good Luck	12. Was Deceden	t Ever in U.S.	13 1		784	nanic Oric	nin? /Sne	oify Vas or No-	U.S.	A . ace - Ameri	can Indian
36	ges 1 and 2 should be liled within 72 hours after death with the maryland if frem 27 is marked other than "natural", or items 23a or 28a-f ehow from 27 is marked other than "natural", or items 23a or 28a-f ehow or other treumatic event, the Medical Examinar must be nutilised at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☒ Marrie  3 ☐ Widowed 4 ☐ Divorced	Agried Forces	? 1 No		f Yes, specifi	-	Specify:	, Puerto F	cify Yes or No- Rican, etc.)		lack, White,	etc.
5-0036	fural Fig.	edt	15. Decedent's			16a. Dece	dent's Usual	Occupat	tion		1	16b. Kind of	Business/In	dustry
215		Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4ol	.54)	(Give life.	kind of work DO NOT use	done du retired)	ıring most	of working	ng			,
2121	giene. er then "	E O	12	Conlege (1 40)	34)	Supe	rvisor	r				C & P	Teleph	none Company
p	d other event, I	Be (	17. Father's Name (First, Middle, L.	*							(First, Middle,		ame)	
Maryland	z snoulo be filed within and Mental Hygiene. ie marked other than eumatic event, the Mental than the Mental th	ပ္	Carl Theodore				=				rginia			-
Mar	h and h and 7 ie m reum		19a. Informant's Name/Relationshi				•				Route Numbe	-		
	Health tem 27		Jennie P. Bauer  20a. Method of Disposition	- wire	20b. Plac	ce of Dispo	sition (Name	of			lew Car:	POLLEO: 20c. Location		
	rages nent of l ant: If it		1 ☑ Burial 2 ☐ Cremation : 4 ☐ Donation 5 ☐ Other (See		cen	netery, crer	natory or other	er place,	· 1	3/30	/2006			Maryland
ıltir.	2 2 2 2		21. Signature of Funeral Service Li		FOLC						ch's F			
B	Depa impo any ii		Men L. Yul	ille							, Hyati		-	
			23a. P.m1. Enter the disease, or c slock, or heart failure. List o	omplications that cause	ed the death.	Do not ent	er the mode	of dying,	, such as o	cardiac o	respiratory ar	rest,		Approximate Interval Between
P	hysician		Imm diate Cause (Final dise se or condition		VCER	2	LUI	V 6						Onset and Death
	/Medical Examiner		resulting in death)	_ a	s a conseque									
	LAMITHE	<u>.</u>	Sequentially list conditions,	P. EVI	5 3 QUASHONH	STA	16	RE	ENA	L	DISE	ASE	_	
3	nsit	Examine	d any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Cae to for a	a a surveorista	risid (Ut)								
	n and al-tra	Xar	that initiated events resulting in death) Last	c Due to (or a	s a conseque	nce of):								
8760,	cate be executed physician and the burial-transit	dicai		d										
68	nincate ng phys as Ihe	led	IF FEMALE.											
Вох	attending pt	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 monthe?	23c. If yes, outcom	e of pregnance 2 Fetal de		Ectopic preg	nancy				1	Date of deliver	ery Day Year
Records, P.O. Box 6	the at	Physician/Me	1 Yes 2 No	4□Pregnant 9□Unknown	at time of dea	th 5 ☐	Other (spec	cify)				•	VICELLI	Cay rear
<u>G</u>	ed by the a		Part II. Other significant condition	s contributing to death	but not resulti	ina in the u	nderlvina cau	ise diver	n in Part I.		23e. Did to	bacco use co	entribute to t	he cause of death?
ds,	signed I	d by	DIABETES	MELL	-	•					1 □ Y	es 2⊟No	3 □ Prot	pably 4 Unknown
Record	been	ete									24a. Was a	ın 24t	. Were auto	ppsy findings available
Re	ate has	Completed									autop: perfor	med?	prior to co death?	mpletion of cause of
		a	25. Was case referred to medical						26. Place	of Death	(Check only or	2 No	1 🗆 Yəs	2 No
of Vita	is car	To B	examiner?	Hospital: 1 ☐ Inpat	ient 2 🗆 Ef	VOutpatien	t 3 DOA	Other	4   Nur	rsing Hom	ne 5 Resid	ence 6 🗆 C	ther (Specif	ý)
			27. Manner of Death 1 ⊟Natural 5 □ Pending	28a. Date of In (Month, D	jury 2 ay Year) 2	8b. Time of Injury	280	. Injury a	at		8d. Describe h			
Sio	death. ctor: A y the fu	cati	2 Accident investiga 3 Suicide 6 Could no				М		es 2 🗆 N					
Division	after death Director: /	Certification;	4 Homicide determin		njury - At hom atc. <i>(Specify)</i>	e, farm, str	eet, factory,	office		2	8t. Location (S City or Tow	treet and Nut n, State)	nber or Rura	al Route Number,
	ours a		29a, Certifier Certifying	Physician: To the bes	t of my knowle	edge death	occurred at	the time	date and	I place a	nd due to the c	ause(s) and	manner as s	tated
3	to the hospitel of Attentions within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Medical	(Check only 2 ☐ Medical E	xaminer: On the basis and manner s	of examinatio	n and/or in	vestigation, in	n my opi	nion, deat	h occurre	d at the time, o	late and place	e, and due to	o the cause(s)
,	withir To th	Me	29b. Signature and title of certifier				29c. l	License	number		2	29d. Date sign		
	-		> Illiper	MD				DO	050	95	ſ	3/2	8/0	6
CI	2 (5)	a	30. Name and address of person w	ho completed cause of	death (Item 2			ver	da	10	ms	207	37	
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 9 20		trar's Signatur	Spen	B							

Edward Paul Burroughs

State of Maryland / Department of Health and Mental Hygiene | |

11202

		•	1 - State Registrar		Cei	rtificate of	Death		Reg. No.	000	16.06
			1. Decedent's Name (First, Middle, La	st)				2. Date of Do	eath Day	Year	3. Time of Death
	Physici		EDWARD	PAUL	BUR	ROUGHS,	III	March		2006	11:00 P <sup>M</sup>
1	/Medic Examir		4a. Facility Name (If not institution, gir	re street and number)		4b. City, Town, o				County of Death	
	Exa		3206 Branch Aven	ue		Temple	Hills			Prince (	George's
	Funeral		5. Social Security Number 6.	Sex 7. Age (II	yrs. last birthday)	If Under 1 Year	If Under 24 H				place (State or Foreign intry)
	Director		212-25-4662 Usual Residence of Decedent	X M 2 □ F 1	9 Yrs.	Months Days	Hours M	9-16-			HINGTON,DC
	yland		10a. State 10b. County	10	c. City, Town or Lo	cation					10d. Inside City Limits
	r 28a-f ahow	to	DC		WASHIN	GTON					1 X Yes 2 □ No
	death with the Maryland rms 23s or 28s-f show f must be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Cou	intry?
	3a or	0	3518 6th STRE	ET. SE #9		2.0	032			U.S.A.	
	death	Funeral	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or N		4. Race - Ameri	ican Indian,
G			1 XNever Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ No		If Yes, specify Cuba		erto Hican, etc.)		Black, White	
93	hours after tural", or ite	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□ Yes 🌠 No	Specify:		3	Specify: BI	LACK
21215-0036	72 ho	Completed	15. Decedent's E		16a. Dece	dent's Usual Occup	ation	varkina	16b. Kin	nd of Business/Ir	ndustry
215	within 7 ene. then "r he Mad	p P	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	during most or (	vorking			
21	77 2 2 20	PO	12th			STUDENT				N/A	
Þ	単正さる	0	17. Father's Name (First, Middle, Las	)			18. Mother's N	lame (First, Middle	, Maiden S	Sumame)	
<u>la</u> i		To B	EDWARD	PAUL B	URROUGH	S, II	GWEN	DOLYN		GREENE	E
Maryland	d 2 should th and Mer th in marke traumatic		19a. Informant's Name/Relationship	Type, Print)	19b. Mailir	ng Address (Street	and Number or	Rural Route Numb	er, City or	Town, State, Zi	p Code)
	l and 2 lealth a im 27 lu her tra		GWENDOLYN GREE	NE - MOTHE	R 2803	KEITH	ST., TE	MPLE HI	LLE,	MD 2	20748
ē,	- T 4 5		20a. Method of Disposition		20b. Place of Dispo	sition (Name of matory or other plac	(20)	Date	20c. Loc	ation - City or T	own, State
Baltimore,	0 0		1 Burial 2 Cremation 3 4 Donation 5 Other (Special Control of the	Removal from State	•			31-2006	CLI	NTON	MARYLAND
Ē	permit. Page Department. Important: if any injury o		21. Signature of Funeral Service Lice								TERAL CHAP
Ba	permit. Departn Imports any inju		156	b. 201					-		LAINS, MD
			23a. Part1. Enter the disease, or con	polications\that caused the				-	-		Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.		_		14			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aMU	utiple	Guus	not we	runds	>		
	Examiner			Due to (or as a co	onsequence of):						
		er	Sequentially list conditions,	b. Due to (or as a ct	-11200 OF						-
	ed isit	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		onsequence on.						
	end end -tran	Examine	that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of):						
60,	oe ey cien ouria	E E		545 (5) (5) 25 2 5	37.554251.56 517.						
68760,	icate be executed physicien end s the buriat-transit	edical		_ d.						-	
×	entifi ding	Me	IF FEMALE:	22a Huas autoema of a							
Bo	ath c	ician	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p	Fetal death 3	Ectopic pregnancy	,		23	<ol> <li>Date of deliving</li> <li>Month</li> </ol>	∕ery Day Year
	It the death by the atte	sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at tim 9□Unknown	e of death 5L	Other (specify)					,
P.0		by Phys	**************************************	enstellerting to doubt but a	at requities in the		on in Dant I	220 Did	tohoooous	a contributo to	the cause of death?
Ś	es the		Part II. Other significant conditions	contributing to death but h	ot resulting in the u	nderlying cause giv	en in Part I.		1.	1	the cause of death?
ord	w requir been si should	ted						- ''	Yes 2 🗸	No 3□Pro	bably 4 Unknown
ပ္မ	e law r has be	Completed						24a. Was		24b. Were auto	opsy findings available ompletion of cause of
ñ	The ste h	щo						1 Xes	ormed? 2□No	death?	
ita	sician: The la certificate ha	0	25. Was case referred to medical				26. Place of D	eath (Check only			
Division of Vital Records,	nding Physician: ath. r: After this certific e funeral director.	0	examiner? 1 ☆ Yes 2 ☐ No	Hospital:	2 ER/Outpatier	nt 3 DOA Oth	er: 4 Nursing	Home 5□Res	idence 6	Other (Speci	(v) Scene
0	g Ph er th er th	n:T	27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time o	f 28c. Injur Wor		28d. Describe			
<u>0</u>	nding ath. r: After e funer	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	01 1	10,748		Yes 2 No	sul	uct	shot	
<u>Vis</u>	after des Diractor	€	3 Suicide 6 Could not l 4 Homicide determined	28e. Place of Injury building, etc. (5	At home, farm, str	eet, factory, office		28f. Location	Street and		al Route Number,
Ö	affer Dira	ert	412 Normeide	Statu				TPI	wn, State)	32.06 F	Brauch Ave
	hours a uneral C	Medical Certification:	29a. Certifier 1 Certifying P	hysician: To the best of m	v knowledge, deat	h occurred at the tir	ne, date and pla	ice, and due to the	cause(s) a	and manner as	stated.
	a Ho a Fu letely	dic	one)	miner: On the basis of ex- and manner stated	amination and/or in	vestigation, in my o	pinion, death or	courred at the time	date and p	place, and due t	to the cause(s)
_	To the Hospitel or Al within 24 hours after or To the Funeral Dirac completely filled in by	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Date	signed (Month,	, Day, Year)
	->-0		1 ( n & to L	A 0000	u.d	OCM	F.		Ma	arch 26,	2006
	0 (2)		30. Name and address of person who	completed cause of docate	(Item 23a) /Tuma		-		PIE	иси ∠0,	_ 2000
0/			(AR) HAT	A LANCA OF GRAD	. ( 20a) ( 1 ype,		nn Stree	et Baltim	nore	Marv1 or	nd 21201
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's	Signature		- DOLE	DULULII	.010,	ini yidi	21201
	Registi			2. Registrar's	K has	E)					
			MAR 2 9 200	Man .	-						

Months

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

4b. City, Town, or Location of Death

BETHESDA

If Under 1 Year If Under 24 Hrs.

Hours

Days

LINDA ANN BORDEN

7. Age (In yrs. last birthday)

3. Time of Death

2:45 P M

9. Birthplace (State or Foreign Country) San Fran-Cisco, Calif.

10d. Inside City Limits

1 X Yes 2 □ No

Reg. No.

20

Day

United

Year

MONTGOMERY

States

Race - American Indian, Black, White, etc.

Specify: Black

16b. Kind of Business/Industry

National Guard

20c. Location - City or Town, State

Maryland

23d. Date of delivery

1 Yes 2√2 No 3 Probably 4 Unknown

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

Month

20011

Interval Between Onset and Death

Cheltenham

2006

4c. County of Death

10g. Citizen of What Country?

2. Date of Death

Month

MAR

**Physician** /Medical Examiner

**Funeral** 

1 - For State Registrar

5. Social Security Number

Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

6. Sex

1 □ M 2 🕅 F

death. in by the Director

within 24 hours after To the Funeral Dire State Registrar

pellij

Medical

the Hospital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MATTHEW NEEDLEMAN LTMC USN

0101236852 (VA)

29d. Date signed (Month, Day, Year) 2

28f. Location (Street and Number or Rural Route Number, City or Town, State)

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 Suicide

4 - Homicide

(Check only

MAR 2 9 2006

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			1_ For State	State of Maryla				-		an c	11201
			1 - State Registrar		Ce	rtificate	of Death		leg. No.	JUD	11204
П	Physici	an	Decedent's Name (First, Middle, Last	)				2. Date of Dea Month	ith Day	Year	3. Time of Death
>	/Medic	al	Theodore L  4a. Facility Name (If not institution, give			4b. City, To	wn, or Location of Dea	March 2		2006 County of Deat	11:10PM <sup>M</sup>
	LXamii	iC1	7105 Panorama Dri			Rocky	ille		Мо	ntgome	rv
	Funeral		5. Social Security Number 6. Se		s. last birthday)	If Under 1 `			1		nplace (State or Foreign untry)
	Director		578-03-5459 X	92	Yrs.			11/01/1	913	Was	nington DC
	yland		10a. State 10b. County	10c. C	ity, Town or Lo	ocation					10d. Inside City Limits
	Ba-f s	Director	Maryland Montgome	ry Roo	ckville						1 ☐ Yes 2 No
	with th	Dire	10e. Street and Number			10f. Zip Co				en of What Co	untry?
	eath	erai	7105 Panorama Driv	2. Was Decedent Ever in	U.S. 13	208			U.S.	A. 4. Race - Ame	ncan Indian.
ယ	or item	Funeral	1 ☐ Never Married 2 💢 Marned	Armed Forces? 1 ☐ Yes 2 ☐ <b>X</b> No			t of Hispanic Origin? ( Cuban, Mexican, Pue	rto Rican, etc.)		Black, White	e, etc.
ğ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any njury or other traumatic event, it a Medical Exantical Exantical and ADEs.	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1□Yes 2□	No Specify:			Specify: W	nite
Maryland 21215-0036	"natu	Completed	15. Decedent's Edu (Specify only highest grad	ication le <i>completed)</i>	(Give	dent's Usual ( kind of work of DO NOT use i	done during most of w	orking	16b. Kin	d of Business/	ndustry
7	l withii iene. r than	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)			Engineer		11 5	. Gove	enmont
פ	al Hyg othar	BeC	17. Father's Name (First, Middle, Last)		12100	1011163		ame (First, Middle,			-IIIICH U
<u>s</u>	Mente Mente arked	ToE	Henry Alexander B	enz			Burbie	Sanford			
Jar	and rand		19a. Informant's Name/Relationship (T)  Cathryn Davis (Da				treet and Number or F				lip Code)
	1 and Health em 2		20a. Method of Disposition		Place of Dispo		treet Herr	Date VA	201 20c. Loc	Ation - City or	Town, State
Baltimore,	ages ant of ht: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	ABITIOVALITORII ŞLALB			al Pk 3/2	20/2006			
=======================================	pertme		21. Signature of Funeral Service Licens					National			
Ö	Dep Impo		Signa of	Zori	0	7482 Le	e Highway				2042
P.			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the dea ne cause on each line.	ath. Do not ent	ter the mode of	f dying, such as cardia	ac or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. Dilate	d Car	dom	pathy				vears
11 K	Examiner		ar months in vote -	Due to (or as a conse	quence of):	1. n. de	photogos				Upans
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse		DV.	0.000				1002
	acuted nd transi	Examiner	that initiated events	c							
760,	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	cal Ex	resulting in death) Last	Due to (or as a conse	equence of):					- 4	
587	icate physics the			d							
X	nding use a	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregi		7-			23	3d. Date of del	very
œ.	death	sicla	in the past 12 months? 1 ☐ Yes 2 DNo	1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown		Ectopic pregi Other (speci				Month	Day Year
P.O. Box 68	at the	by Physician/Med	9 Unknown					nn- Bides	h		the saves of death?
ds,	signe d be d	d by	Part II. Other significant conditions co	-	isulting in the u	nderlying caus	se given in Рал I.	239. Dig 10	_	_	the cause of death?
COL	w requires to been signer should be c	lete	nitrai Regu		-			24a. Was a		•	topsy findings available
Vital Records,	The lay	Completed	Hyperlipidem	•				autop		prior to death?	ompletion of cause of
ta	ician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of De	1 ☐ Yes eath (Check only or		1 163	2 140
	Physic this ce al direc	Tof	TE Tes 22500	lospital: 1   Inpatient 2	☐ ER/Outpatier		Other: 4 Nursing	Home 5 Resid	ence 6	Other (Spec	eify)
Division of	ling P	lon:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Tîme o Injury	28c.	injury at Work?	28d. Describe h	ow injury	occurred	
ISI(	Attending Physician: The law requires that the death certifical ordeath.  actor: After this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the funeral director.	ertification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At	home, farm, str		1 Yes 2 No	28f. Location (S	treet and	Number or Ru	ral Route Number,
2		Certi	4 Homicide	building, etc. (Spec	eify)	, , .		City or Tow	n, State)		
	To the Hospitel or Attending within 24 hours after death.  To the Funeral Diractor: After completely filled in by the funer		(Check only 2 Medical Exami	sician: To the best of my kr ner: On the basis of examin	nowledge, death	h occurred at l	he time, date and place	e, and due to the coursed at the time	ause(s) a	and manner as	stated. to the cause(s)
	To the H within 24 To the F complete	Medical	one) 29b. Signature and title of certifier	and manner stated.	27000111		icense number			signed (Mont)	
)	7 × 1 0		PULLANDO POR COM	Ocala S.	~						
P	(15)		30. Name and address of person who ca	ompleted cause of death (Ite	em 23a) (Type,	Print)			., 20	J 11	
1			Priscilla Callah	an-Hon m	911	Lust	041794 211 Ave 1	saithers b	ury,	mo a	90879
	Sta Registr		31. Date filed (Month, Day, Year)	. Registrar's Sign	nature	2.				•	

Certificate of Death

BARTEL

4b. City, Town, or Location of Death

Chevy Chase

2. Date of Death

March 27,

Day 2006

4c. County of Death

Montgomery

14. Race - American Indian, Black, White, etc.

20012

23d. Date of delivery

1 Yes

29d. Date signed (Month, Day, Year)

03/27/06

Day

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2 🗆 No

Month

Approximate Interval Between Onset and Death

Year

Specify: white

Dental

Leo

7. Age (In yrs. last birthday)

96

Yrs.

1. Decedent's Name (First, Middle, Last)

5. Social Security Number

076-12-4369

Usual Residence of Decedent

4a. Fecility Name (If not institution, give street and number)

6. Sex

1₩ 2□F

Manor Care Nursing Home

**Physician** 

/Medical

Examiner

**Funeral** 

Director

3. Time of Death

4:30 A M

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Tes X No

29c. License number

FACP, 5411 W. Cedar Ln., #202A, Bethesda, MD

н 45839

DHMH 17 Rev 1/2001

State

Registrar

29b. Signatur

and title of certifier

MAR 28

Gary E. Raffel,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.O.,

200\$

32. Registrar's Signature

		State of Maryland / Depart State of Maryland / D		
	ysiciar Medica	NNOLOO, NIVIVI	Moni	of Death th Day Year 3. Time of Death 3. 2006 4c. County of Death
	amine	Suburban Hospital	b. City, Town, or Location of Death  Bethesda  Under 1 Year   If Under 24 Hrs.   8, Date	Montgomery
Dire	ector		onths Days Hours Min. (Mon	of Birth hith Day, Year)  ch 15,1925 Charlottsville Virginia
e Marylan	iffed at	MD 10a. State 10b. County 10c. City, Town or Locati Rockville	on	10d. Inside City Limits 1 (∑Yes 2 □ No
oth with the	ust be notified	10e. Street and Number 6121 Montrose Road	101. Zip Code 20850	10g. Citizen of What Country? United States
1215-0036 within 72 hours after deeth with the Maryland ene.	any injury or other traumatic event, the Medical Examinar must be notified at once.  To Be Commissed by Finneral Director	11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  13. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:	Decedent of Hispanic Origin? (Specify Yes is, specify Cuban, Mexican, Puerto Rican, et Yes 2 XNo Specify:	or No- tc.)  14. Race - American Indian, Black, White, etc.  Specify: Black
Baltimore, Maryland 21215-0036  Sermit. Pages 1 and 2 should be filed within 72 hours att Deperment of Health and Marial Hygiens. The moortant: if Item 27 is marked other than "patural" or	moleted	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  6th  16a. Decedent (Give kin. life. DO Private	's Usual Occupation d of work done during most of working NOT use retired)	16b. Kind of Business/Industry
land 2	atic event, it	17. Father's Name (First, Middle, Last)	Deputy Nurse  18. Mother's Name (First, A  Agnes Fortu	
Ore, Maryla es 1 and 2 should to of Heelih and Markes	er traumat	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing A	ddress (Street and Number or Aural Route ) Navahoe Drive Silver	
imore Pages 1 t	do of	20a. Method of Disposition  1	ory or other place)	20c. Location - City or Town, State Riverdale, Maryland
Balt permit. Dependent	any inj	382	tin Royster Funeral 1 14th Street NW Was	shington DC 20011
SPECTOR OF THE PROPERTY OF THE	lical	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter it shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  S * uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	le mode of dying, such as cardiac or respira  function  Textine	Approximate Interval Between Onset and Death
Box 6	be deteched for use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ect 4 □ Pregnant at time of death 5 □ Ot	opic pregnancy her (specify)	23d. Date of delivery  Month Day Year
rds, P	ald be dete	Part II. Other significant conditions contributing to death but not resulting in the under	tying cause given in Part I. 23e	Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒Unknown
918/8 NOTA Vital Records, P.O iclan: The law requires that the certificate has been signed by the	pag 5		10	. Was an autopsy performed? Yes 2 No 1 □ Yes 2 □ No
Sn of	completely filled in by the funeral director.  Medical Certification: To Be (	1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient		only one)  Residence 6 Other (Specify)  cribe how injury occurred
Division Division outs of the desired	lled in by the funera		City	ttion (Street and Number or Aural Route Number, or Town, State)
Divisid	ompletely fil	29a. Certifier (Check only one)  1X Certifying Physician: To the best of my knowledge, death or continuous and mariner stated.	curred at the time, date and place, and due tigation, in my opinion, death occurred at the 29c. License number	to the cause(s) and manner as stated.  time, date and place, and due to the cause(s)  29d. Date signed (Mgnth, Day, Year)
	2	30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	D0057591/	3/4/2008
Re	State egistrar	31. Date filed (Month, Day, Year) APR 0 6 2006  32. Begistrar's Signature	5530 WISCONS	100 1 CHASE MD 2018/19

			1 - For State Registrar	State of Marylan	•	artment of H tificate of L			iene	16	11207
	Dharist		Decedent's Name (First, Middle, Last)					2. Date of Deal Month	h Day	Year	3. Time of Death
	Physicia /Medic		RITA MARI	E BER	RRY			MARCH			8:10P M
À.	Examin		4a. Facility Name (If not institution, give str	,		4b. City, Town, or			4c. County	of Death	
			Holy Cross Hosp	pital			r Spri	_	Mon	tgom	nery
	Funeral Director		5. Social Security Number 6. Sex 215-94-0131	7. Age (In yrs. 54	last birthday) Yrs.	Il Under 1 Year Months Days	Hours Mi		, 1952	Cour	lace (State or Foreign ryland
	and w		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	dary	ō	MD Montac	marr	Coi	thersbu	<b>36</b> 07				1. XYes 2 □ No
	288-	Director	MD Montgo	mery	Gal	10f. Zip Code	19	1	0g. Citizen of V	What Cour	ntry?
	Sa or	□	7909 Coriander	Drive #103	}		879		U.S.		, .
	ne 2	era		. Was Decedent Ever in U.				(Specify Yes or No- erto Rican, etc.)			an Indian,
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatile and Mental Hygiene.  Important: If them 27 is marked other than "natural" or Items 23s or 28s-f show eny injury or other traumette event, I'm Medical Examinar must be notified at once.	by Funeral	1 ☑ Mever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 2 No Il Yes, Give Year or Dates;		f Yes, specify Cubai 1 □ Yes 215 No	n, Mexican, Pui Specify:	erto Rican, etc.)	Specify	k, White,	etc. .ack
3	hour		15. Decedent's Educa		16a Decec	dent's Usual Occupa	ation		16b. Kind of B	icinecs/In	duetor
2	in 72 i "na ledic	Completed	(Specify only highest grade	completed)	(Give	kind of work done of DO NOT use retired,	luring most of w	rorking	16b. King of bi	12111622/111	bustry
7	with ene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)		estic			Pr	ivat	e
3	Hyg Hyg other ent,		17. Father's Name (First, Middle, Last)				18. Mother's N	ame (First, Middle, i			
5	ld be ked i	To Be	George H. Berr	ry Sr.			Chr	istine I	E. Lin	coln	
2	shound M	-	19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailin	ng Address (Street a	and Number or	Rural Route Number	. City or Town,	State, Zip	Code)
Ĕ	alth a		Rochelle L. Berr	rv-Daughter	7909	Corian	der Dr	#103 G	aither	shur	MD2087
<u>ה</u>	f Hei		20a. Method of Disposition	20h F	lace of Dispo	sition (Name of natory or other place			20c. Location -		
2	ar ar ago		1 ☐ Burial 2 【Cremation 3 ☐ Read 4 ☐ Donat]on 5 ☐ Other (Specify)			unl Svc		29/06	Alexa	ndri	a, VA
	artm orta		21. Signatur Funeral Service iconseq					nowden I			
ă	Depar Depar Impor eny tr		Leage V.	much		246 N.	Washin	gton St	Rockv	ille	, MD20850
			23a. Part1. Enter the disease, or complications shock, or heart failure. List enty one	ations that caused the de	no not ent	er the mode of dying	g, such as card	iac or respiratory arr	est,		Approximate
	Physician		Immediate Cause (Final	//							Interval Between Onset and Death
ř.	/Medical		disease or condition resulting in death)	CARDIAC A  Due to (or as a conseq						-	
	Examiner			STROKE	20.100 0.7.						
١,		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to (or se a conseq	usines of).						
	uted d ansit	Examiner	Cause (Disease or injury that initiated events								
ĵ	be executed icien and burial-transit	Exe	resulting in death) Last	Due to (or as a conseq	uence of):						
000	cate be executed physicien and the burial-transit	dlcal	d.								
5	tifica ng ph as th	led	15 55 11 5 1 5 1 5 1 5 1 5 1 5 1 5 1 5								
5	th cer endir r use	1	230. Was decedent pregnant	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fete		Ectopic pregnancy			23d. Da	te of delive	
•	deat	300	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of d		Other (specify)			Mo	nth	Day Year
	at the by th	Physician/Med	9 Unknown								
ברים. ברים ברים	w requires that the death certific been signed by the ettending p should be detached for use as	by	Part II. Other significant conditions control Hypertension	ibuting to death but not res	ulting in the u	nderlying cause give	en in Part I.		bacco use cont es 2⊠No		ne cause of death?
ב כ	aw req	Completed	Diabetes Mellit	us				24a. Was a		Were auto	psy findings available
č	The I	E	End Stage Renal	Disease				autops perfor	med?	death?	mpletion of cause of
<u> </u>	stan: artific ctor,	Be (	25. Was case referred to medical examiner?				26. Place of D	eath (Check only or			
<u>-</u>	hysic lidire	2	1 ☐ Yes 2 ☒ No	spitat: 1 ☐ Inpatient 2 🖸	ER/Outpatien	nt 3□ DOA Othe	er: 4 🗆 Nursing	Home 5 ☐ Resid	ence 6 □Oth	er (Specif	ý)
) =	ng PI fter ti		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injury Work	at c?	28d. Describe h	ow injury occur	red	
NISION I	endin eath. or: A he fu	atl	2 Accident investigation				Yes 2 □ No				
Š	of or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, str (y)	eet, factory, office		281. Location (S City or Tow		er or Aura	al Route Number,
	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours elater death.  To the Funderal Director: After this certificate hes been signed by the ettending p compistely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier 1 ☐ Certifying Physic (Check only one) 2 ☐ Medical Examine	cian: To the best of my kno er: On the basis of examina and manner stated.	owledge, death	n occurred at the time vestigation, in my of	ne, date and pla pinion, death oc	ace, and due to the courred at the time, d	ause(s) and ma late and place,	anner as s and due to	tated. the cause(s)
	To the vithin to the complex c	₩e	29b. Signature and title of certifier	0		29c. License	number	2	9d. Date signe	d (Month,	Dey, Year)
			Miousi	è kulter	100	D56	691		Marc	h 24	, 2006
		- Contraction	30. Name and address of person who com	pleted cause of death filer	I ZSa) (Type						•
			Dr. Ghousia Sa				rk Civ	Ciltro	r Chri	næ	MD 20006
	Sta	ite	31. Date liled (Month, Day, Year)	32. Registrar's Signa	ature	Laye Pa	TV 141	· ottae	PALT	119.	20300
	Registr		MAR 2 8 2006	Blown B	100						

Physician
/Medical
Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other treumetic event, it a Mudical Examinat must be netified at once.

To Be Completed by Funeral Director

Certification: To Be Completed by Physician/Medical Examiner

Twild Virginia Brackman

Baltimore, Maryland 21215-0036 Physician /Medical **Examiner** within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Host ital or Attending Physician: The law requires that the death certificate be exer Division of Vital Records, P.O. Box 68760, 6-H-0 State

For State Registrar		State of M			rtment of He			ene (	6	11208
1. Decedent's Name	e (First, Middle, La	est)	<u> </u>				2. Date of Death	<b>J. 110.</b>		3. Time of Death
Twila		Virgini	a		Brackman		Month	Day 1	Year	MY' MAM
4a. Facility Name (I	f not institution, giv	re street and number)	-		4b. City, Town, or Lo	cation of Death	MAG	4c. Count	y of Death	07,00
Fahre 5. Social Security N	4-Kee	dy Nur	e (In yes. last birt.	ne	Boonsb	0	8 Date of Birth	Was	Shin	State or Foreign
235-62-78	806	1 ☐ M 2 💢 F				Hours Min.	8. Date of Birth (Month, Day, ) July 21.	/ear)	Cour	ntry)
Usual Residence of	Decedent		<u> </u>				July 21,	1921	west	Virginia
10a. State	10b. County		10c. City, Town	or Loca	ation				1	0d. Inside City Limits
MD	Washing	ton	Hager	eto	L.M					1 Yes 2 No
10e. Street and Nur			nager	. 5	10f. Zip Code		100	. Citizen of	What Cour	atov2
20103 Te	fferson	R1vd								itty:
11. Marital Status	TICIBON	12. Was Decedent	Ever in U.S.	13 W	as Decedent of Hispa	anic Origin? (Sne	acity Ves or No-	U.S.	A • ce · Americ	an Indian
	ed 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give Year or Dates:		lf '	Yes, specify Cuban,	Mexican, Puerto Specify:	Rican, etc.)		ick, White,	etc.
	15. Decedent's E	ducation	16a.	Decede	nt's Usual Occupation	on .	16	ib. Kind of B		
	ify only highest gra			(Give ki	ind of work done duri O NOT use retired)	ing most of worki	nn	Electr		dustry
Elementary/Secon	nuary (0-12)	College (1-4or 5	Li	ne W	Worker (Wi	nder)	1	lanufa		no
17. Father's Name (	First, Middle, Last	)					(First, Middle, Ma			
David God	ldard					Nannie .			,	
19a. Informant's Na	me/Relationship (	Type, Print)	19h	Mailing	Address (Street and			life or Town	State Tie	Codel
Cheryl B										Code)
20a. Method of Disp		Sircer	20b. Place of	Disposit	Jeffersor	BIVa.,		OWN . M. c. Location		742
1 Burial 2		Removal from State y)	cemetery	r, crema	ntory or other place)  Cemetery			gerst	•	
21. Signature of Full	neral Service Lice	nsee		160	Name and Address of 1 Pennsy1	of Facility Rev	st Haven	Funer	al Ch	apel
23a. Part1. Enter th	e disease, or com	pleations that caused one cause on each lin	the death. Do no						11, 111	Approximate
shock, or hear Immediate Cause (		one cause on each lin	ю.	1	1/ 1 +	- 1		•		Interval Between Onset and Death
disease or condition resulting in death)		a. Cou	gostou	2 /	Leave t	allany	0			162
, , ,		Due to (or as	a consequence o	f):						
Sequentially list con	nditions,	b	Arren	rd						30×
if any, leading to im cause. Enter Under	tvina	Due to (or as	a consequence of	f):						/
Cause (Disease or i that initiated events resulting in death) L		c								
resulting in death) L	ası	Due to (or as	a consequence of	f):				_		
	•	d								
IE EENALE.										
IF FEMALE: 23b. Was decedent	pregnant	23c. If yes, outcome		ء 🗆 ت				23d. Da	te of delive	ry
in the past 12 r 1 □ Yes 2 🕏		1□Live birth 4□Pregnant at			ctopic pregnancy Other <i>(specify)</i>					Day Year
9 ☐ Unknown		9□ Unknown								
Part II. Other signifi	cant conditions c	ontributing to death bu	t not resulting in	the und	ertying cause given in	n Part I.	23e. Did tobac	co use cont	ribute to th	e cause of death?
							1 Tes	_	3 🗌 Proba	
							24a. Was an autopsy		prior to con	sy findings available appletion of cause of
							performe		death? 1 ☐ Yes	2 🗆 No
25. Was case referre	ed to medical				26	. Place of Death	(Check only one)			
1 ☐ Yes 2 ☑	No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outp	patient	3□ DOA Other:	4 Nursing Hon	ne 5 🗆 Residenc	e 6 □Oth	er (Specify	)
27. Manner of Death	5 C B - # -	28a. Date of Injur (Month, Day			28c. Injury at	7	8d. Describe how			<u>′</u>
1 ☑Natural 2 ☐ Accident	5 Pending investigation		1041)	jury	Work? M 1 ☐ Yes	2 No				
3 Suicide	6 Could not be determined	28e. Place of Inju	ry - At home, farr	n, street	t, factory, office	2	8f. Location (Stree	t and Numb	er or Rural	Route Number
4 🗌 Homicide		building, etc	. (Specify)				City or Town, S	itate)		
29a. Certifier (Check only one)	Certifying Ph	ysician: To the best of	examination and	death or	ccurred at the time, o	date and place, a	nd due to the caus	e(s) and ma and place, a	inner as sta	ated. the cause(s)
29b. Signature and t		and manner sta			29c. License nu					
Loo. Oignaturo una t	nig or certino				29C. License III	/ Inde	290.	Date signed	a (Month, L	ay, rear)
<	25					1535	3	158	18	
30. Name and addre	ss of person who	completed cause of de	ath (Item 23a) (T	ype, Pri	int)		17.7.7			
Down	) was	een 112	6000	1 0	t. Har	ers twi	my:	177	0	
31. Date filed (Month		32. Registra	r's Signature							
l	MAR 302	006	as A.	Sono	while I					
		1	10	La lan	- V					

Registrar

Medical

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 25, 2006 ar **Physician** Benny Leonard Beal 03:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 12610 Bruce House Row Road Mount Savage Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) 23-May-1923 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 M 2□ F Hours 218-12-5254 82 West Virginia Yrs. Director Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits 27 is marked other then "naturel", or items 23a or 28e-f show treumatic event, the Medical Exertiner must be notified at Maryland Allegany Mt. Savage 1 Yes 2 No 10e. Street and Number 12610 Bruce House Row Road 10f. Zip Code 10g. Citizen of What Country? 21545-U.S.A. 2 should be filed within 72 hours after death in and Mental Hygiene.
Is marked other then "naturel", or Items 23s Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: W W □ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) during most of working Elementary/Secondary (0-12) College (1-4or 5+) railroad carman railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Beal Laura Albright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 st of Health ar fitem 27 l Jacquelyn Beal 12610 Bruce House Row spouse Mount Savage Maryland 21545 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Sunset Memorial Park 29-Mar-2006 Cumberland Maryland ` 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 L. Enter the disease, or complications that caused the death. ck, or heart failure. List only one cause on Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to per as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed burial-transit and as a consequence of) physician as the burial Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Other: 2 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred After To the Hospitel or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie D0054411 rson who completed cause of death (Item 23a) (Type, Print) Vame and address of pe MRS Calkins Ave. Ste. 105, Cumberland, Md. 21502 500 Memoria M.D. 31. Date filed (Month, Day, Year) 2. Registrar's Signature State MAR 2 8 2006 Registrar

			1 - For State Registrar	State of M	larylan		artment of H		nd Me		iene eg. No.	36	1210
	D!		1. Decedent's Name (First, Middle, L.	ast)					2	Date of Dea Month	th Day	Year	3. Time of Death
	Physici /Medi		Clare	Josephi	ne	E	ourdeau		1	March 2			3:00 P M
}	Examir		4a. Facility Name (If not institution, gi	ve street and number)	)		4b. City, Town, or	Location of	Death		4c. Cou	nty of Death	
L			Country House				Cumber		d Ura			llegan	
	Funeral Director		, ,	- C C	ge ( <i>in yr</i> s. i 91	last birthday) Yrs.	Months Days	Hours	Min.	. Date of Birth (Month, Day	, Year)	Coun	,,
			Usual Residence of Decedent		7.1			1		10/27/	1914	New J	ersey
	yland		10a. State 10b. County		10c. City	y, Town or Lo	cation			· · · · · · · · · · · · · · · · · · ·		10	0d. Inside City Limits
	e-f sl	cto	MD Alleg	any		Cumb	erland						1 X Yes 2 □ No
	or 28	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen	of What Coun	try?
	filed within 72 hours after death with the Maryland Hygiene. Other than "netural", or itams 23a or 28e-1 show ent, the Medical Exertingt roust be neitlised an	la l	1 Baltimore	Street				21502			US	SA	
	tams	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	?	S. 13. Y	Was Decedent of Hi f Yes, specify Cuba	ispanic Origi In, Mexican,	in? (Specif Puerto Ric	fy Yes or No- can, etc.)		Race - America Black, White, 6	
30	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ If Yes, Give Year or Dates:	No		I□Yes 2⊠No	Specify:			Spe	cify:	
9500-61212	hour	ed h	15. Decedent's E			16a Decer	lent's Usual Occupa	ation	-		16h Kind o	W In f Business/Ind	ite
Š	n "ne	Completed	(Specify only highest g	rade completed)	- 1	(Give	kind of work done of DO NOT use retired	during most	of working		TOD. KING O	Dusiness/inc	lustry
7 7	d with piene r tha	E	Elementary/Secondary (0-12)	College (1-4or	5+)		Bookk	eeper			Conva	lescen	t Home
<u> </u>	e filec of he vent,	BeC	17. Father's Name (First, Middle, Las					18. Mother	's Name (F	First, Middle, I			
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "netural", or itams 23a or 28e-f show aumatic event, the Medical Examiner must be netitied at	70 E	Clarence	Habers	tick	Herr		1	Irene			Ма	rtin
a	s 1 and 2 should I Health and Mer itam 27 is marke other traumatic		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	g Address (Street a	and Number	or Rural F	Route Number	, City or Tox	wn, State, Zip	Code)
2	of Health of Health litem 27 i		Raymond D. Bour	deau / son			. Box 18	5, Lon					
o e			20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	☐Removal from State	-	lace of Dispo emetery, cren	sition (Name of natory or other plac	Θ)	Date	е	20c. Locatio	on - City or To	wn, State
<u>=</u>	. Pages tment of tant: if it jury or o		`4 □Donation 5 □Other (Spec	ify)			d Cremato					rland,	
baltimore,	permit. Page Department of Important: if eny injury or		21. Signature of Funeral Service Lice	allone			Name and Addres  4 Decatus						Home, P.A. 502
Г	4		23a. Part1. Enter the disease, or cor shock, or heart failure. List on	nplications that causer y one cause on each l	d the death	. Do not ent	er the mode of dyin	g, such as c	ardiac or re	espiratory arre	est,		Approximate Interval Between
k	Physician		Immediate Cause (Final disease or condition	Cong	octiv	e Hear	t Failure	2					Onset and Death
П	/Medical		resulting in death)	Due to (or as	a consequ	uence of):	L railuit	<b>3</b>					
	Examiner		Sequentially list conditions.	b									
	Si ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequ	uence of):							
	and and I-tran	хап	that initiated events resulting in death) Last	c Due to (or as	200020	ience of):							
8/60,	be ey ician buria	alE		200 10 (0) 23	a consequ	101103 OI).							
20	icate be executed physician and s the burial-transit	dical	•	d									
	the death certificate be executed y the attending physician and iched for use as the buriai-transit	/Me	IF FEMALE:	23c. If yes, outcome	of pregna	ncy					234	Date of deliver	24
DOX	atter for u	clar	23b. Was decedent pregnant in the past 12 months?	1⊡Live birth 4⊡Pregnant a	2 Fetal	death 3	Ectopic pregnancy Other (specify)						Day Year
j.	the c y the	Physician/M	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9 Unknown									
	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions	contributing to death b	out not resu	ulting in the ur	nderlying cause give	en in Part I.		23e. Did tot	acco use c	ontribute to th	e cause of death?
coras,	quire in sig uld b		Alzheime	ers Disease	e					1 □ Y€	s 2KINo	3 Proba	abiy 4 Unknown
္ဌ	faw reas bee	olet								24a. Was a	n 24	b. Were autop	sy findings available
T E	The tate ha	Completed					-			autops perform	ned?	death?	pletion of cause of
VII		0	25. Was case referred to medical					26. Place o	of Death (C	Check only on		1 1 1 1 0 3	2 140
	Physicien: this certific ral director,	To B	examiner? 1 □ Yes 2 ሺ No	Hospital: 1 Inpatie	ent 2 🗆	ER/Outpatien	t 3 DOA Othe	) F)		5 🗌 Reside		Other (Specify	sisted
10 L	ng Pt fter th		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry ay Year)	28b. Time of Injury	28c. Injury Work	at	280	d. Describe ho	w injury occ	curred	<del></del>
UIVISION	andii eath. or; A the fu	catl	2 Accident investigation					Yes 2□N	0				
Ë	iract n by 1	ertification;	3 Suicide 6 Could not determined		jury - At ho tc. <i>(Specif</i> y	me, farm, str	eet, factory, office		28f	Location (St. City or Town	reet and Nu , State)	mber or Rural	Route Number,
_	urs al	0											
	To the Hospital or Attanding Phys —within 24 hours after death. To the Funeral Diractor: After this completely filled in by the tuneral di	edical	29a. Certifier 1∑ Certifying P (Check only 2 Medicel Exe	hysician: To the best miner: On the basis o and manner st	of examinat	wledge, death ion and/or inv	occurred at the tim restigation, in my or	e, date and pinion, death	place, and occurred	d due to the ca at the time, da	use(s) and ate and plac	manner as sta e, and due to	ated. the cause(s)
	To the within To the complex c	Me	29b. Signature and title of certifier	/	)	<del></del>	29c. License	number		2:	9d. Date sig	ned (Month, L	Day, Year)
	ا ا		1681 B	2061	10	20	DO	034231			March	30, 2	006
	Thes		30. Name and address of person who	completed cause of c	death (Item	23a) (Type.	Print)						
	1100		Robin Bisse				,	Grant	svil	le. Man	rvland	2152	6
J	Sta		31. Date filed (Worth, Day, Year) MAR 3 1 2006	32. Registr	rar's Signat	ture	K ,				<del></del>	·	
	Registr	aŗ	SILLIN O T CODO	1 min	المحمداني	fre the to	and the same of th						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** MARY YARNALL BRAKE MARCH 27 2006 1:20 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frostburg, MD

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | MAY 4, 1912 St. Vincent DePaul Nursing Center Allegany 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2**X**0F 220-10-0285 93 **Director** MARYLAND Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "natural", or items 23a or 28a-f show treumatic event, the Medical Examinar must be notified at by Funeral Director 1 ☐ Yes 🌂 ☐ No MONTGOMERY CHEVY CHASE 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 4730 BRADLEY BOULEVARD 20815 U.S.A. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 XWidowed 4 ☐ Divorced Specify. WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry . Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) SALES CLERK RETAIL STORE UNKNOWN 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fit ment of Health and Mental H tent: If item 27 is marked ott and Mental F JOHN VINCENT YARNALL ELIZABETH т. HART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIA WINIARSKI/NIECE & GUARDIAN 123 SCHELL ROAD, JOPPA, MD 21085 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Importent: if any injury or once. MARY'S CEMETERY 03/30/2006 ' 4 ☐ Donation 5 ☐ Other (Specify) CUMBERLAND, MD 21. Signature of Funeral Service License 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Priysician Advanced 6 months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Box 68760 by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy igned by the atter in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 🗆 Yes 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 🗙 No Certification: To 3 DOA this hours efter death.

Inerel Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide within 24 hours a To the Funerel L To the Hospitsi Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 00055325

nes

3

State Registrar

31. Date filed (Month, Day, Year) MAR 2 9 2006

WONSOCK

wowsorker

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHIN

MD 48 Tarn Registrar's Signature

Terrace Frostburg MD21532

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year Physician 12:25 AM March 28, 2006 Burns Ruth V. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Berlin, Maryland Wo Worcester Berlin Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 🕱 F 86 Yrs. Baltimore, MD Director 217-05-5532 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or iteme 23a or 28a-f show the Medical Examinant trust by contilled at 1 ☐ Yes 2 ☐ No Selbyville Delaware Sussex Direct 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? United States 37739 N. Shady Drive 19975 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing 9 Book Binder 7 le marked other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be finand Mental H Be William J. Kennedy Edna- Maiden name unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37814 Salty Way Fast, Selbyville, DE of Disposition (Name of Date 20c. Location Henry J. Burns/son Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place)
Cape Henlopen
Crematory 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Depertment of H important: If ite eny injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 3-28-2006 Frankford, Delaware 21. Signature of Funeral Socice Liganses 22. Name and Address of Facility Melson Funeral Services, Ltd. West Ave., Ocean View, Delaware 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardovosculo **Physician** treus. /Medical Examiner Sequentially flat conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Physician: The law requires that the deeth certificate be executed physicien are s the burial-t Due to (or as a consequence of): P.O. Box 68760, Physician/Medical ettending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 Unknown this certificate has been si al director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 2 No 1 Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death
Natural
Death
Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation after death | Director: / d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aff To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature Name and address of person who completed cause of death (Item 23a) (Type, Print) Coostel Helia Nicholas E 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARCH 26 2006 7:36am EDNA ELIZABETH BROWN BARNES /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner CIVISTA MEDICAL CENTER LA PLATA CHARLES | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Worth Day Year | 1928 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F MARYLAND 77 Yrs. 216-22-2832 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Directo PORT TOBACCO MARYLAND CHARLES 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 20677 7280 BARNES PLACE UNITED STATES Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: Specify: BLACK þ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than College (1-4or 5+) 9TH GRADE condary (0-12) **ELDERCARE** HEALTH INDUSTRY Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental Pages 1 end 2 should be GEORGE F. BROWN ROSE LEE BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit Pages 1 end 2 a Department of Health as Important; If Item 27 is any injury or other trau once. 7280 BARNES PLACE, PORT TOBACCO, MARYLAND EDNA BROWN JORDAN / DAUGHTER 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ZION BAPITST CHURCH CEMETERY APRIL 1,2006 WELCOME, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21 LATURE OF FUNDING STREET ST THORNTON FUNERAL HOME, P.A 3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DVANCED HOST YERL SEASK **Physician** RONC طرم disease or condition resulting in death) /Medical Due to (or as a consequence-of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine physicien and the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as the attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No o been signed by the should be detached 9 Unknown 9 Unknown م Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗌 No 1 Yes 1 Yes 2)X No Division of Vital Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 10 20 No 2 ER/Outpatient 3 DOA 1 Inpatient this 28a. Date of Injury (Month, Day Year) After thi funeral of 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation s efter death 2 Accident completely filled in by the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours e To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signaturie and title of certifier who completed cause of death (Item 23a) (Type, Print) and address of person WALDORG-M WATHEN MD. TENNEST 32. Jegistrar's Signature 31. Date filed (Month, Day, Year) State MAR 2 8 2006 Registrar

		_	State Registrar	State of Maryland		nt of Health and N te of Death	Mental Hygie Reg. 2. Date of Death	7 111115	3. Time of Death
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last) WILLIAM JENNINGS BE		4b Cib	, Town, or Location of Death	Month 03	Day Yeer 26 2006  4c. County of Death	6:47 P M
	Examin Funeral Director	er	4e. Facility Name (If not institution, give st. 1716 WEST CLEARLAKE 5. Social Security Number 6. Sex 1121			SALISBURY er 1 Year I if Under 24 Hrs.	8. Date of Birth (Month, Day, Ye 02-12-195	WICOM 9. Birth Cou	
	Maryland e-f show	tor	Usual Residence of Decedent           10a. State         10b. County           MD         WI COMIO		Town or Location				10d. Inside City Limits 1 ☐ Yes 2 💢 No
00	within 72 hours atter death with the Maryland ene. Than "natural", or items 23e or 28e-f show na Medical Examinari, sist the mullisulat	by Funeral Director	1 ☐ Never Married 2X Married	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	. 13. Was Dec	ip Code  21804  edent of Hispanic Origin? (Siecify Cuban, Mexican, Puerting 2XI No Specify:		USA  14. Race - Amer Black, White  Specify: W]	ican Indian,
21213-0030	ges 1 and 2 should be filed within 72 hours after de the the than Aental Hygiene. If I than 27 is marked other than "natural", or flems or other traumatic event, the Medical Evantharia.	Completed b	3 Widowed 4 Divorced  15. Decedent's Educi (Specify only highest grade  Elementary/Secondary (0-12)	completed) College (1-4or 5+)		vork doné during most of wor use retired)	king 161	b. Kind of Business/I	
2	uld be filed with the state of	To Be Cor	12 17. Father's Name (First, Middle, Last) WILLIAM JENNINGS BE	RYAN, SR.	INSURANC	18. Mother's Nan	ne (First, Middle, Mai		<u> </u>
	and 2 shou ealth and N m 27 is mei har traumai		19a. Informant's Name/Relationship (Type MARY BRYAN - SPOUSI	Ε		SS (Street and Number or Ru RLAKE DRIVE, S	SALISBURY,		21804
Dalillioie,	t. Pa rtmer rtent njury		20a. Method of Disposition    Burial 2   Cremation 3   Re	moval from State JERU	metery, crematory of ISALEM CEM	(ETERY 03-30	)-2006 <u>PA</u>	RSONSBURG	,MARYLAND
3	Depa Impo impo any ii		23a. Part1. Enter the disease, or compile shock, or heart failure. List only one	ations that caused the death.	705 E	AST MAIN STRE		URY, MARYL	
	Physician // Medical Examiner   Wasician and	Examiner	Immediate Cause (Final disaase or condition resulting in death)  Saquentiaty list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):	ac (ell Can	(CINOMI	a	18 mo
. 200 voc	death certific e attending pl od for use as t	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \frac{\mathbb{A}}{\text{No}} \) 9 \( \text{Unknown} \)	ic. If yes, outcome of pregnan  1  Live birth 2 Fetal ( 4 Pregnant at time of dea	icy death 3⊟Ectopic			23d. Date of deli Month	very Day Year
, L	The faw requires that the death ite has been signed by the atte bage 2 should be detached for	by	Part II. Other significant conditions conf	tributing to death but not resul	lting in the underlying	g cause given in Part I.		cco use contribute to	the cause of death?
		Completed					24a. Was an autopsy performe	d? prior to death?	topsy findings available completion of cause of 2 No
	ding Physician: Th n. After this certificate funeral director, pag	on: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 5 No  27. Manner of Death  1 Natural 5 ☐ Pending		ER/Outpatient 3 28b. Time of Injury	DOA Other: 4 Nursing F 28c. Injury at Work?	ath (Check only one) dome Standard 28d. Describe how		cify)
	or Attendition of Att	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At hor building, etc. (Specify)		1 ☐ Yes 2 ☐ No ory, office	28f. Location (Stree City or Town,	et a <i>nd Number or R</i> u State)	iral Route Number,
	To the Hospitel or At within 24 hours after of To the Funarel Direct completely filled in by	edical	(Check only 2 Medical Examin one)	ician: To the best of my know er: On the basis of examinati and manner stated.	ion and/or investigati	on, in my opinion, death occu	irred at the time, date	and place, and due	to the cause(s)
	To II To II	Σ	29b. Signature and title of certifier  Aul A Henry	jus		29c. License number 0 2 4 8 7 2 4 5 7 0	3	Date signed (Month	n, Day, Year)
	St.	ate	30. Name and address of person who & PAUL R FLEURY  31. Date filed (Month, Day, Year)  MAR 2 8 20	32. Pogistrar's Signati		st Po	conoke	City MD	21877

		1	For State Registrar	State of N	Maryland		artment of I				giene Reg. No.	006		215	
Phy	sicia		1. Decedent's Name (First, Middle,	Last)						Date of Dea Month	ath Day	Year		of Death	
	edica	1	Elbert C. F			1			arch?				50 M		
Exa	mine		4a. Facility Name (If not institution,		or)	0/	4b. City, Town,	or Location	of Death		46.0	4c. County of Death .			
				S. Sex 7.	Age (In yrs. ia	ast birthday)	If Under 1 Year		er 24 Hrs. 8.	Date of Birt	th	7-7-	rthplace (Stat	e or Foreian	
Fune Direc			221-03-3287	1 <b>X</b> M 2□ F	87	Yrs.	Months Days	beurs	Min.	Date of Bird (Month, Da -19-1	y, Year) 919	0	DE .	_	
P.		-	Usual Residence of Decedent  10a. State 10b. County											2	
arylar		.	¥7V-												
he M		901	Md. Wicon	1100	cp town					10g. Citizen of What Country?					
with a		Funeral Director	403 Railway St.			10f. Zip Code 21861				US		ountry?			
leeth ns 23		era	11. Marital Status	nt Ever in U.S	5. 13.		Hispanic O	Origin? (Specify	Yes or No			encan Indian			
rs after o		by Fun	1 ☐ Never Married 2 【XMarrie 3 ☐ Widowed 4 ☐ Divorced	Armed Force	s? ⊒No 1941	_	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 No			an, etc.)	Black, White, etc.  Specify: White				
ILK ID-UU30 within 72 hours after deeth with the Maryland ane. then "naturel", or Items 23e or 28e-f show he Madical Examiner must be notified at	8	eg -	15. Decedent's	Education		16a. Dece	dent's Usual Occu	pation			16b. Kind of Business/Industry				
		Completed	(Specify only highest Elementary/Secondary (0-12)	Grade completed) College (1-46	or 5+)	(Give	kind of work done DO NOT use retire	during mo d)	ost of working						
A with		000	12		Desi	gner	т			Ny1c	nt				
DESIGNATION CO. MALY STATES AND SO SENTING TO THE SOURCE STATES OF SENTING MANY SENTING TO THE SENTING		Be	17. Father's Name (First, Middle, L.						her's Name (F						
	1	0	Elbert C. Baile					1	enda K						
		i	19a. Informant's Name/Relationshi Erline M. Bailey			ng Address <i>(Str</i> ee Railway					1861				
Heeling		-	20a. Method of Disposition	, will	20b. Pl	ace of Dispo	osition (Name of	1	Date				r Town, State		
ant of the state o			Burial 2 Cremation :		10	-	matory or other pla		3_31_0	6					
Datimit. Peges Department of mportant: If it	once.	İ	4 Donation 5 Other (Specify)  Laurel Hill Cemetery 3-31-06  Laurel, De.  21. Signature of Funeral Service Licensee  Hannigan Short Disharoon Funeral Home												
		+	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate												
Physici /Medic			Immediate Cause (Final disease or condition resulting in death)  a. Many Many Aparches  British and Death  Consolidation a. Many Many Aparches  Consolidation a. Many Many Many Many Many Many Many												
Examir	ner		Due to (or as a consequence (f): /												
פ פ	į .	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequ	ence of).									
ecute	8	Kam	that initiated events resulting in death) Last	c. Due to (or	ance of										
OK DE/DU, certificate be executed iding physicien and		Ical E		200 10 (01	u3 u 001136qu	ionico or).									
OO/		adic		d											
Geath death e atter	e e e e e e e e e e e e e e e e e e e	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2 months?  4 □ Pregnant at time of death  5 □ Other (specify)									23d. Date of delivery Month Day Year		
COTOS, P.O. I w requires that the de- s been signed by the a should be deteched to	8 .	2	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									d tobacco use contribute to the cause of death?  ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown			
ecords taw requires es been sign		etec													
<b>a</b> a a a	bagar	Completed						24a. Was autopenfo	psy prmed?	24b. Were a prior to death?	completion	igs available of cause of			
OT VITAL P Physician; Th rthis certificete	100	Be	25. Was case referred to medical examiner?						ce of Death (C	heck only o	one)				
Physic rthis c	a  '	္	- Simplified College of the College												
		ation:	27. Manner of Death  1 Main Natural 5 □ Pending 2 □ Accident investigation	ation	28b. Time o Injury	of 28c. Injury at Work?  M 1 Tyes 2 No									
or At or At or At	ka lii bi	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	reet, factory, office	actory, office 28f. Location (Stre City or Town,					et and Number or Rural Route Number, State)					
Fo the Hospital within 24 hours error to the Funeral Commonwell of the	Ē	edicai	29a. Certifier (Check only one)  1  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2  Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
To the within 2		Σ	29b. Signature and title of certifier		29c. License number 29					9d. Date signed (Month, Day, Year)  3/28/0(					
130	1/K	-	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  JOHN Koutenberg 205 S. DIVISION ST, SALISBURY MD, 21801												
	Stat	e	31. Date filed (Month, Day, Year)	32. Red	istrar's Signat	ture		770	15001-4	TVI()	, 21	301			
Reg	gistra		MAR 2 S	2006	was ,	K 1	Carl.								
DHMH 17 Re	v 1/20	01			·	17									

			For	540									lental Hy		-		11016		
		_1	State Registrar								Death			Reg. No	UU	)	11210		
Phy	sicia		I. Decedent's Nam	e (First, Middle,	Last)								2. Date of De Month		ay Year 3. Time		3. Time of Death		
/M	ledica	al -	Willie a. Facility Name (	Columb			r)		4b City	Town or	Location	of Death	Mar.19,2006			f Death	15:05p. M		
Exa	amine			rn Mary						into		o. Dout.			Prince Georges				
Fune	5.	5	. Social Security N		6. Sex 1 ☑ M 2 □	7. A		last birthday) Yrs.		r 1 Year	If Under Hours	24 Hrs. Min.	8. Date of Bi				place (State or Foreign		
Direc	tor	2	40-68-43 Usual Residence of	22 f Decedent			02	**************************************					Nov.1	194	43	Nort	h Carolina		
nyland	3	.	I 0a. State	10b. County				ty, Town or Lo							10d. Inside City Limits				
Ba-f		Ö	MD.	es	Capitol Heights									1 ☐ Yes 2 🙀 No					
with ti	9												ntry?						
death me 23	Ē	_	1212 Capitol Heights Blv  11. Marital Status  12. Was Dece				t Ever in U	20743 Was Decedent of Hispanic Origin? (Spe if Yes, specify Cuban, Mexican, Puerto F				U.S.A ecify Yes or No-							
s after	au lus	y Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced			1 ☐ Yes 2 N No			1 □ Yes 2 ☑ No Specify:				mican, etc.)		Black, White, etc.  Specify: Black				
DETITIESTIEST WAT YIGHT A LICE SHOOTS  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Itema 23a or 28a-f show	EX.	ed by	3 Widowed	15. Decedent		ducation 16a. Deced			dent's Usual Occupation						d of Business/Industry				
7 Pin 72	Media	Completed	(Spec	cify only highest	grade comple	College (1-4or 5+)  (Give			kind of work done during most of worki DO NOT use retired)				ing						
y gien	<b>1</b>	Con	10			Truc				ck Driver							cking Industry		
I be fill ntal H	- A	m l	17. Father's Name (First, Middle, Last)								e (First, Middle								
shoulk nd Me	mati	၉	19a. Informant's N	ert Bro ame/Relationsh		')		19b. Maili	ng Address	(Street a			Sharpe Sharpe		or Town, S	itate, Zip	Code)		
and 2	er tra		Sherita	Baker(D	aughtei	r)							,Capito	_					
Des 1.	or oth	2	20a. Method of Dis	position Cremation	3 □Removal	from State		Place of Dispo cemetery, crea					Date		ocation - C				
Dallillo Demit. Pages Department of Moortant: If I	) and		4 Donation	5 Other (Sp	ecify)		Pir	ne Viev		_	,	3-25			ky Mt	-	.C.		
Depa	once once		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Hilliard Funeral Home P.O.Box 626, Whitakers, N.C. 27891-0626																
Ŷ.		1	23a. Part1. Enter t	he disease, or our failure. List of	complications to	hat cause	ed the dear								91-00	20	Approximate Interval Between		
Physic	ian		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Mulastatic Caps Three Car ce											Onset and Death					
/Medi Exami			resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):																
· ·	_	ē																	
cuted	ransii	CTS	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.																
ite be executed ysician and	urial-i	a Ex																	
wrequires that the death certificate be executed been signed by the attending physician and	eu s	2			d														
DIVISION OF VITAL INSCRIPTIONS, P.O. DOX 00 To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.	es es		IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes	s, outcom	e of pregn	ancy	7						23d. Date of delivery				
death	<b>ed</b> Tor	sicia	in the past 12 months?  1  Yes 2  No  4  Pregnant at time of death 5  Other (specify)									Month Day Year							
hat the	Jetach	Phy.	9 Unknown  Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use									uco contrib		no agus of doub?					
w requires to been signer	90 0	Completed by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use											B 🔲 Prot					
s beer	nous z	olete	24a.								24a. Was								
The la	page	E C					-						auto perfe	prior to completion of cause of death?  2 1 Yes 2 No					
cian:	ector,	Be	25. Was case referred to medical examiner?																
Phys.	in di	2	1   Yes 2   10   Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Residence 6   127. Manna of Death   28a. Date of Injury 2   28b. Time of 1   Natural 5   Pending   28b. Describe how injury occurs   1   Natural 5   Pending   28b. Time of 1   Natural 5   Pending   28b. Time of 1   Natural 5   Pending   28b. Time of 1   Natural 5   Pending   28b. Time of 1   Natural 5   Pending   28b. Time of 1   Natural 5   Pending   28b. Time of 1   Natural 5   Pending   28b. Time of 1   Natural 5   Pending   28b. Time of 1   Natural 5   Pending   Natu											y)					
Attending or death.	e tune	atlor	1 Natural 2 Accident	lay Year)	Injury	М	Worl	<br Yes 2□			.,	aution .							
r Atte	by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, building, etc. (Specify)							et, factory, office 2				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Function of the contribution of the contr	Deli																		
a Hos 24 ho	etely	edical	29a. Certifier Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											tated, the cause(s)					
To th To th	d E o o		29b. Signature and	title of certifier	7				29	c. License	number			29d. Da	ite signed	(Month,	Day, Year)		
			Ant						S	50454					March, 20,06				
12)			30. Name and addr	ess of person v	who completed	cause of	death (Iter	m 23a) (Type,	Print)	Ent	La.		1 1	10	20	74	U		
to the s	Stat	e l	7900//L 31. Date filed (Mon	ith Day, Year)	~ 10 2	2. Regis	trar's Signa	2 -77	0 /	UY	~us	my	In A	مدانا		- /	7		
Re	gistra		MAI	2 4 20	06	inte	K	Asses	W										

			For State Registrar		State o	f Maryla	nd / Depa			lealth a Death	and M		giene Reg. No	UUD	\$-701/needed	1217
	Div.		1. Decedent's Name (	First, Middle, La	ast)							2. Date of Dea	ath Dav	/ Yea		. Time of Death
	Physici /Medi		Virginia	a		Burnet	t					0.3	22	06		3:00 A M
	Examir		4a. Facility Name (If no	_		mber)		4b. City	, Town, or	Location o	f Death		4c.	County of De	ath	
			11313 Shi 5. Social Security Num		Sex	7 4 (1			linto	n If Under 2	24 Hea			Prince		
в	Funeral Director		246-66-532		1	63	s. last birthday) Yrs.	Months		Hours	Min,	8. Date of Birt (Month, Da	y, Year)		Country)	(State or Foreign
			Usual Residence of De						1	L		01 07	43	S IN	IC	
	how		10a. State	0b. County	7, 1/2	10c. C	City, Town or Lo	ocation							10d. l	Inside City Limits
	Se-f s	cto	MD :	Prince	Georges	(	Clinton						_			1∏ Yes 2 ☐ No
	or 28	Dire	10e. Street and Number					10f. Zi	p Code	. =			_	izen of What (		
	s 23a	Funeral Director	11313 Shi	rl Cour					207					nited S		
	Item Item	nne	11. Marital Status 1 ☐ Never Married	2□ Marriad	12. Was Dec		U.S. 13.	Was Dece If Yes, spe	edent of Hi ecify Cuba	ispanic Orig n, Mexican	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)	-	14. Race - An Black, Wh		ndian,
936	urs af	by	3⊠ Widowed 4 [		If Yes, Gir Year or D	/e		1 🗆 Yes	2 <b>X</b> No	Specify:				Specify: B]	Lack	
21215-0036	within 72 hours after death with the Maryland ans. then "natural", or Items 23a or 28e-f show the Marical Examinat must be notified at	Completed		5. Decedent's E			16a. Dece	dent's Usu	al Occupa	ation	and communicate in		16b. Ki	nd of Busines		ry
21	d within 72 ho giene. r then *natu	nple	Elementary/Seconda		ade completed) College (	I-4or 5+)	life.	DO NOT	ise retired	during most ()	OF WORKE	ig				
2			12		8		Tea	cher			,				choc	1 System
Maryland	o d fa b	Be	17. Father's Name (Fit		t)							(First, Middle,		Sumame)		
Ž	should be tnd Menta s marked umatic ev	ပို	James M.  19a. Informant's Name	-	(Tyne Print)		19h Maili	na Addres	s (Street s			Route Numbe		r Tour State	Zio Coo	70.l
	2 m m		Charvonne B			r	A1529 887 786								, <i>21</i> 0 000	20)
<u>6</u>	of Health item 27	13.2	20a. Method of Dispos	ition		20b.	Place of Dispo cemetery, crei	sition (Na	me of		Di	iton, M		cation - City o	or Town,	State
Ë	0 0		1 🖾 Burial 2 🔲 0 `4 □ Donation 5			State Re	esurrec			· 1	03-2	8-06	C1:	inton,	MD	
Baltimore,	permit. Pag Department Importent: I any injury o once.		21. Signature of Funer	ral Service Lice	nsee)	10				_		ickland	Fir	neral S	Servi	ices
<u>m</u>	88 28		· Eric	· D.	Stru	Klas						, Camp				
г		,	23a. Part1. Enter the shock, or heart fa	disease, or con ailure. List only	nplications that of one cause on e	aused the dea	ath. Do not ent	ter the mo	de of dying	g, such as o	cardiac or	respiratory ar	rest,	10.15	Inte	proximate erval Between
	Physician	i E un	Immediate Cause (Fir disease or condition	nal	a. Hype	rtensi	ve Athe	rosc	lerot	ic Ca	rdio	vascula	ar D	isease		set and Death
	/Medical Examiner	. :	resulting in death)	(		(or as a conse										
		<u>.</u>	Sequentially list condi-	tions,	b. Hype	rtensia orașa sonsa	on.								-	
	uted d ansit	Examiner	Sequentially list condition by leading cause. Enter Underlyi Cause (Disease or injuthat initiated events	ng ury			Heart	Enil:	120							
o Î	the death certificate be executed y the attending physician and tched for use as the burial-transit		resulting in death) Las	t	Due to	or as a conse	equence of):	rall	are_							
8760,	cate be ex physician the burial	dlcal		- (	d											
9	artifica ing ph e as th	0	IF FEMALE:			A - 1 - 1 - 1 - 1										
Box	eath certific attending p for use as	lan/	23b. Was decedent pr in the past 12 mg			irth 2 🗆 Fel	tal death 3[	Ectopic					1	23d. Date of de Month	elivery Day	Year
o.	that the de ad by the a detached f	Physiclan/M	1 ☐ Yes 2 🔯 N 9 ☐ Unknown		4⊟Pregr 9⊟ Unkn	ant at time of own	death 5	Other (s	pecify)						,	
<u>α</u>	that ti led by detac		Part II. Other significa	nt conditions	contributing to de	eath but not re	sulting in the u	nderlying	cause give	en in Part I,		23e. Did to	obacco u	se contribute	to the ca	ause of death?
Records,	requires that een signed b hould be deta	d by	Atrial	Fibril.	lation							1 🕱 Y	res 2[	□No 3□F	Probably	4 Unknown
00	> 40 0	lete	Histor	r of Tol	oacco Us	ie.						24a. Was	an	24b. Were a	autopsy f	findings available
	The te h age	Completed		01 10.	0000							autop perfor	rmed? 22 No	death?	comple s 2	tion of cause of
Vital		BeC	25. Was case referred examiner?	to medical						26. Place	of Death	(Check only or				
of <	Physicien: this certific ral director,	To	1 ☐ Yes 2X No			<del></del>	☐ ER/Outpatier			4 🗀 Nui	sing Hor	e 5 <b>X</b> Resid	tence (	6 □Other (Sp	ecity)	
	ing After unal	on:	27. Manner of Death 1 X Natural 5	5 🗌 Pending		of Injury th, Day Year)	28b. Time of Injury		28c. Injury Work			8d. Describe h	now injur	y occurred		
Sic	ten for: the	icat	2 Accident	investigation  Could not b	OB Place	of Injune - At I	homo form etc	M .		Yes 2 N		8f. Location (S	Stroot on	d Number or C	Burni Co.	uto Altimbos
Division	of or Attend after death Director: / d in by the f	ertification;	4 Homicide	determined	buildi	ng, etc. (Spec	home, farm, str hify)	eet, ractor	y, onice			City or Tow			nurai noi	ute Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	O	29a. Certifier 1	Certifying P	hysician: To the	best of my kr	nowledge, deatl	h occurred	at the tim	e, date and	d place, a	nd due to the o	cause(s)	and manner a	as stated	
	the Ho hin 24 t the Fu npletely	edical	(Check only 2 [ one)	Medical Exa	miner: On the b	asis of examin	ation and/or in	vestigation	n, in my op	oinion, deat	h occurre	d at the time, o	date and	place, and du	e to the	cause(s)
	To the within To the comple	×	29b. Signature and title	e of certifier	0/	6		29	c. License	number		2	29d. Dat	e signed (Mor	nth, Day,	Year)
^	50		16/10	n t	1	- Kin	LVIY	0	D	00555	39		03-	-22-06		
pl	-(3)		30. Name and address				m 23a) (Type,	Print)	nd '	MD 20'	716					The state of the
	9		Eugene Tay			egistrar's Sigr		u_t_ta	uia, i	20 كلية.	740					
	Sta Registr	-		2 7 200			Local	80								

# Amend # 25 per Phy. 3-23-06 A.A.Co.Health Dept. PM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of	Maryla	nd / Depa <i>Cei</i>	artment tificate			and M		giene Reg. No.	00	6	112	8
	Physic		Decedent's Name (First, Midd     Ida	le, Last)			Boswe:	11				2. Date of De Month March	ath Day 16	20	ear 06	3. Time of E	Death M
	/Medi Examir		4a. Facility Name (If not institution	n, give s	treet and num	nber)	DOD!! C	4b. City, T	own, or	Location o	of Death	- Haren		County of		2313	
	Lxaiiiii		Baltimore Was	hing	gton Me	dical	Center	Glen					A	nne	Aru	ndel	
	Funeral Director		5. Social Security Number 217–32–2977	6. Sex	M 2 7 F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Months	Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da Oct. 3	th ly, Year) 0,19	37 N	Birthp Cour	place (State or ntry) land	Foreign
	pu ,		Usual Residence of Decedent			140.5											
	ehov	5	10a. State 10b. County			106. 0	City, Town or Lo	cation							1	0d. Inside City	
	28a-f	Funeral Director	MD Anne  10e. Street and Number	Aru	ndel		Odento		2-4-				10- 02	4140			
	with	P						10f. Zip 0		1.0			rog. Citi.	zen of Wh	at Cour	ntry?	
	ne 23	era	494 Bruce Aver		12. Was Dece	dent Ever in	U.S. 13. V	Vas Decede	211 ent of Hi		nin? (Spe	city Yes or No	)- ·	USA 14. Race	Americ	an Indian,	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland hat hygiene.  Id other then "naturel" or iteme 23e or 28e-f ehow event, i're Medical Examinant carefulled at	by Fun	1 Never Married 2 Mar 3 Widowed 4 Divorced	ried	Armed For 1 Tes If Yes, Give Year or Da	ces? 2 <b>X</b> 1No e		Yes, specif		Specify:	, Puerto I	cify Yes or No Rican, etc.)			White,		
Ö	2 hou	Completed	15. Deceder				16a. Deced	lent's Usual	Occupa	tion			16b. Kir	nd of Busi	ness/in	dustry	
215	c * //	pie	(Specify only higher Elementary/Secondary (0-12)	st grade	College (1-	4or 5+)	life. I	kind of work OO NOT use	retired,	uring mosi )	of workii	ng					
7	filed within Hygiene. other then "	ပ္ပ	12			·	Homem	aker	,					wn Ho			
Ind	S should be filed within and Mental Hygiene. Is marked other then aumatic event, the M	Be	17. Father's Name (First, Middle,	,								(First, Middle,	, Maiden	Sumame)			
yla	and Men ie marke	은	Roy Francis Bo									insey					
Var	12 sh h and h and 7 le m		19a. Informant's Name/Relations	, ,								Route Number			ate, Zip	Code)	
	is 1 and 2 should of Health and Mer Item 27 is marks other traumatic		Richard D. Bos	wer.	r (Son)				the second second	the property of the same	PARTITION	ton, M			by or To	wn, State	
Baltimore,	0 = 5		1 N Burial 2 ☐ Cremation		emoval from S	late	Place of Dispo cemetery, cren			1							
턆			4 ☐ Donation 5 ☐ Other (S	-	ef	Ft	Linco	In Ce	_			-2006	Bren	twoo	d, N	1D	
Ba	permit. I Departm Importa any Inju		1 61.1A	4/	7			Harde	sty	Fune	ral 1	Home, F	P.A.	MD	21/	0.1	
	_		23a. Part1. Enter the disease, o	r compli	cations that ca	used the dea	ath. Do not ente		_			Annap r respiratory a		سلام و	214	Approximate	
	Physician		shock, or head failure. List Immediate Cause (Final	only on	e cause on ea	ich line.	-0 6	en v	0/	140	010					Onset and De	
	/Medical		disease or condition resulting in death)	a a	Due to (c	or as a conse	equence of):	1	1	1	4	vej			-	10%	la
	Examiner		Sequentially list conditions	Ь												O	
	p #s	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Į	Due to (d	or as a conse	quence of):										
	and and I-tran	хаш	that initiated events resulting in death) Last	c	Due to /c	or as a conse	guence of):								-		
8760,	sate be executed only sicien and the burial-transit	alE			200 10 (0	71 43 4 001130	quarice or).										
687	ficate physics the	Physician/Medical		d													
Вох	eath certific attanding pl	Z	IF FEMALE: 23b. Was decedent pregnant	23	Sc. If yes, outc	ome of pregr							2	3d. Date	of delive	ery	
	death e atta ed for	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No		4☐Pregna	nth 2 ☐ Fet ant at time of		Ectopic pred Other (spec						Month		Day Ye	ear
P.0	at the by th tache	hys	9 □ Unknown	-	9□ Unkno	wn											
of Vital Records, 8	The law requires that the death certificate be executed tile has been signed by the attanding physicien and bage 2 should be detached for use as the burial-transit	ב	Part II. Other significant conditi	ons con	tributing to de	ath but not re	sulting in the ur	derlying cau	ise give	n in Part I.		23e. Did to				ne cause of de ably 4 ∐Ur	
000	law requasi ss been 2 shoul	Completed				\						24a. Was		24b. We	re auto	psy findings av	vailable
æ	The lay	E O											rmed?	prid dea	r to con	npletion of cau 2□ No	use of
ital		BeC	25. Was case referred to medica	1						26. Place	of Death	1 ☐ Yes	2 No		1 1 0 3	20140	
<u></u>	Physicien: r this certific ral director,	2	examiner? <del>- 1(⊋Yes -</del> 2 反 No	Н	ospital: 1 🔲 In	patient 2	ER/Outpatien	3□ DOA	Othe	r: 4 □ Nu	rsing Hon	ne 5 Resid	dence 6	□ Other	(Specif)	1)	
	ng Ph (fter th		27. Manner of Death 1 ☑ Qatural 5 ☐ Pendir	na	28a. Date of (Month)	f Injury r, <i>Day Year)</i>	28b. Time of Injury	280	c. Injury Work			8d. Describe I	now injury	occurred			
sio	Attending I ir death. ector: After by the funer	cati	2 Accident investi	gation				М		'es 2 □ ħ							
Division	or At after d Direct in by	Certification:	4 Homicide determ		28e. Place o buildin	of Injury - At I g, etc. <i>(Spec</i>	home, farm, stre ify)	et, factory,	office		2	8f. Location (8 City or Tox			or Rura	l Route Numb	Θ/,
	pital burs a eral C		20a Cartifice 1 Cartificia	on Ohora	inter Total		Programme and a	150 D. 4 A	We we	-207-51		04400000000	-Vert of V00	CANT OF	197 V - 51	Seate ==	
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edicai	29a. Certifier Check only 2 Medical one)	Examin	er: On the ba	sis of examin	idwledge, death ation and/or inv	estigation, in	n my op	inion, deat	h occurre	nd due to the id at the time,	date and	and main place, and	due to	the cause(s)	
	To the vithin 2 To the complet	Me	29b. Signature and title of certifie	r		7		1 .		number			29d. Date	signed (	Month,	Day, Year)	
	- > - 0		X. Dell	21.	راء و	he.	0	D	2	64	92			17.			
-		3	30. Name and address of person	who cor	npleted cause	of death (Ite	m 23a) (Type, I			- '				-		3	
_			Riad Dakheel	MD	4000	Mitch	ellvill		d, E	Bowie	, MD	20716					
8	Sta		31. Date filed (Month, Day, Year)	200	S 3 Re	gistrar's Sign	nature										
	Registr	ar	-	-	· July	me 1		1									

Ida Boswell

necolus, r.O. DOA 00/00,	>	Dailliore, mai ylailu 21213-003
The law requires that the death certificate be executed	Ph // Ex	permit. Pages 1 and 2 should be filed within 72 hours a
	y : Vie	Department of Health and Mental Hygiene.
te has been signed by the attending physician and	siced m	important: If Item 27 is marked other than "natural", of
lage 2 should be detached for use as the burial-transit		any Injury or other traumatic event, the Medical Exer
	a	once.

			1 - For State Registrar		State of M	larylan	id / Depa	artme			Men	Re	g. No.	6	1 2 1 9	
	Physici /Medic	217	1. Decedent's Name (First, Mic	RI		B	VR	/ Ah O'h	Taura and		N	Date of Death Month ARCH	Day 20 2	2006	3. Time of Death O7/5AM	I
	Examin Funeral Director	\$ s	4a. Facility Name (If not instituted 187 Acton Rosens Security Number 289-07-7809	ad 6. Sex			last birthday) Yrs.	Ann	apolis	S If Under 24 Hrs Hours Min.	. 8.	Date of Birth (Month, Day, arch 6	Anne	9. Birth	place (State or Foreign	n
	Maryland f show	or	Usual Residence of Decedent  10a. State 10b. Cour  MD Anne	ty Aru	nde1		y, Town or Lo								10d. Inside City Limits	
	h with the P 3a or 28a- at be notif	al Direct	10e. Street and Number 187 Acton Roa	ıd					p Code 2140	3		10	g. Citizen of V		ntry?	
980	filed within 72 hours after death with the Maryland Hygione. this than "natural", or Items 23s or 28s-f show ont, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 🔏 M 3 ☐ Widowed 4 ☐ Divorc	arried	12. Was Deceder Armed Forces 1 Yes 2 If Yes, Give Year or Dates	? ] No		Was Dec If Yes, sp		panic Origin? (S , Mexican, Puer Specify:	specify to Rica	Yes or No- an, etc.)		k, White,	can Indian, etc. Thite	
21215-0036	filed within 72 ho Hygiene. othsr then "natur ent, the Wedical	Completed	15. Deced (Specify only hig Elementary/Secondary (0-12	nest grade		5+)	(Give	kind of w	ual Occupati ork done du use retired)	ion uring most of wo	rking	1	6b. Kind of Bu		dustry	
Maryland 2	ould be filed Mental Hyg tarked oths	To Be C	17. Father's Name (First, Midd Frederick Bur	у					of the state of th	Mary E	11e	n McGr	ew		0.41	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mandal Hygiens. Beginnent of Health and Mandal Hygiens than "natural", or flems 23a or 28a-1 show important: if Item 27 is marked othsr than "natural", or flems 23a or 28a-1 show any Injury or other traumatic event, the Madical Exam ner must be notified at once.		Anja C. Bury  20a. Method of Disposition  1 □ Burial 2XX rematio	(Wif	e)	9	187 Place of Disponentery, cre	Acto	n Road ame of other place)	ı	po1: Date	is, MD	21403 20c. Location -	City or To	own, State	
Baltimore,	permit. Pag Department Important: I any Injury o		4 Donation 5 Other  21. Signature of Funeral Servi	ce License		·		Name Har 12	and Address desty Kidge	3-22 of Facility   Funeral   Ly Aven	l H	ome, P Annap	olis, N		0401095	
1	Physician /Medical Examiner	er	23a. Part1 Enter the discase, shock or heart failure. L'Immediate Cause (Fin disease of condition resulting in death)  Sequentially list conditions, if any, leading to immediate	or complist only or		ROB s a consec	ROVAS quence of):			, such as cardia			st,		Approximate Interval Between Onset and Death	15
8760,	that the death certificate be executed ed by the attending physician and detached for use as the burlat-transit	ilcai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or a	s a conseq	quence of):									
.O. Box 68	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be detached for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	2	3c. If yes, outcom 1□Live birth 4□Pregnant 9□ Unknown	2 Feta	al death 3[	⊒Ectopic ⊒ Other (	pregnancy specify)					te of deliv	ery Day Year	
<u>α</u>	w requires that been signed b should be deta	ted by PI	Part II. Other significant cond		-			ınderlying	cause giver	n in Part I.			acco use cont s 2 □ No		he cause of death?	1
al Records,													ned? De No	Were autoprior to co death? 1  Yes	opsy findings available ompletion of cause of 2 No	a
n of Vital	Phys r this ral dii	on: To Be	25. Was case referred to med examiner?  1 ☐ Yes 2 ☐ No  27. Manner of Death 1 ☐ Natural 5 ☐ Pen	F	lospital: 1  lnpa 28a. Date of In (Month, L	iury	ER/Outpatie		Othor	4   Nursing I	Home	5 Reside	nce 6 Oth w injury occur		fy)	
Division	Attendar death sector:	Certification:	2 ☐ Accident inve	stigation Id not be irmined	28e. Place of I building,	njury - At h etc. <i>(Speci</i>	ome, farm, st	M reet, facto		es 2 No	28f.	Location (Str City or Town		oer or Rur	al Route Number,	
	the Hospital or nin 24 hours afte the Funeral Dir npletely filled in	edical	(Check only 2 Medic one)	al Exami	sician: To the bes ner: On the basis and manner	of examina	owledge, dea ation and/or in	rvestigatio	on, in my opi	inion, death occ	e, and urred a	at the time, da	ate and place,	and due	o the cause(s)	
	with To	M	29b. Signature and title of cert	hay	1.A.	In death (1)	hul	m 2	9c. License	1636	C		Od. Date signe	L Z	0, 2006 10 2/108	
	Sta Registi		30. Name and address of pers  1. CHAF1  31. Date filed (Month, Day, Ye	A.	AVK 32. Regis	COM strar's Sign	8601	Ver	PANS	HIGHN	AY	MILL	LERSVIL	e M	10 21/08	

			For State Registrar	State of M	laryland		artmen rtificat			ind Me		giene Reg. No.	006	direction and	122	20
	ha.	35	1. Decedent's Name (First, Midd.	le, Last)							2. Date of Dea Month	ith Day	Ye		3. Time of E	Death
	Physici /Medic		Mary	Elizab	eth			Bots	ko		March	22	2006	5	10:00	a <sup>M</sup>
4	Examin	100	4a. Facility Name (If not institutio	n, give street and number	)		4b. City,	Town, or	Location o	f Death			County of D			
6		že:	Asbury Solomo						s Isl				alvei			
	Funeral Director		5. Social Security Number 227-32-0022	6. Sex 7. A 1 □ M 2 1 F	gθ (In yrs. la 75	ast birthday) Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Birtl $(Month, Da)$ Aug. 2,	193	0 Vi	Country Country	ce (State or nia	Foreign
	and		Usual Residence of Decedent  10a. State 10b. County	1	10c. City	, Town or Lo	cation							100	I. Inside City	/ Limits
	f ehd	ō	MD Calve	rt	So1	Lomons									1 🗌 Yes	2√No
	28a	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What	t Country	y?	
	h with	ie D	11750 Asbury	Circle				206	88				US	SA		
36	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or Itema 23a or 28a-f ehow ant, the Medical Examirant insit to molified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Mar  3 □ Widowed 4 🏋 Divorced	If Yes Give	? No		Was Deced If Yes, spec			gin? (Spec , Puerto F	cify Yes or No- Rican, etc.)		4. Race - A Black, V Specify:	Vhite, et	c.	
ş	2 hou	ed		nt's Education		16a. Dece	dent's Usua	al Occupa	tion			16b. Kin	d of Busine	ess/Indu	stry	
9500-61212	hin 7.	Completed	(Specify only higher Elementary/Secondary (0-12)	ost grade completed)  College (1-4or	5+)	(Give	kind of wo DO NOT u	rk done d se retired,	luring most )	of workin	ng					
7	giene grene	E O	Liomoniary, coopingary (c 12)	5+		Admin	istra	tor						Ma	ryland	1
B	9 m m >	Be	17. Father's Name (First, Middle,	-							(First, Middle,					
Maryland	ages 1 and 2 should be int of Health and Mental It: If item 27 is marked o	ဂ္	Frank A. Schw	<del>-</del>							Claire					
Ja.	2 sh and ls m		19a. Informant's Name/Relation: Frank A. Schw		rothor		-				Route Numbe				ode)	
	1 and Health tem 27 other tr		20a. Method of Disposition	arenberg (b)		in the last					ate		ation - City		n State	
Baitimore,	Pages nent of h		1 ☐ Burial 2 XCremation		<b>3</b>	lace of Dispo emetery, crei										
	it. Partimer ritant:		4 ☐ Donation 5 ☐ Other (S		Met	ro Cr			s of Facilit		-3006	Bal	timor	e, I	MD	
e E	permit. Page Department Importent: If any injury or once.		21. Signature of Politera Service	L CONSOC		24	Hard	esty	Fune	ral	Home, I	P.A.		01/	0.1	
			23a. Part1. Enter the disease, o	complications that cause	d the death	n. Do not ent	12 R	lidge le of dying	ly Av	cardiac or	, Annar	olis rest,	, MD	1 1	Approximate	
	Physician		shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause on each	line.										nterval Betw Onset and D	
760,	/Medical Examiner  hysician and the purial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or a c. — Due to (or a d.	s a consequ	uence of):										
Š	ertifica ling pt	Med	IF FEMALE:	23e If you system	a of araona											
O. Box	The law requires that the death certificate tie has been signed by the attending physoage 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant : 9 □ Unknown	2 Fetal	death 3[	⊒Ectopic pi ⊒ Other (sp					2	3d. Date of Month			ear
1	ires that t signed by i be deta	Ď	Part II. Other significant condition	. 1	but not resu	ulting in the u		ause give	en in Part I.		23e. Did to	-			cause of de	
Ö	w require been sign	etec		7,000							24a. Was		Odb Was	a autoor	sy findings a	
ě	The law	Completed									autop	sy rmed?	prior	to com	pletion of ca	use of
<del>a</del>			05 111	-1							1 ☐ Yes		1 🗆	Yes 2	₩ No	
=	aician: certifica irector, p	o Be	25. Was case referred to medica examiner?  1 Yes 2 No	Hospital:	tient 2 🗆 I	ER/Outpatier	nt 3 🗆 D0	Othe	-		(Check only one 5 ☐ Resid		Other /	Spaciful		
on of	ding Phys h. After this funeral di	tlon: To	27. Magner of Death 1 SNatural 5 ☐ Pendi	28a. Date of In	ury	28b. Time o Injury		28c. Injury Work		2	28d. Describe h		<del></del>	<i>эрвспу)</i>		
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely illied in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could	I not be 28e. Place of Ir	njury - At ho etc. (Specify	ome, farm, st	reet, factor	y, office		2	28f. Location (3 City or Tox		Number o	or Rural	Route Numb	<i>101</i> ,
	To the Hospital of within 24 hours at To the Funeral D completely filled it	Medical C		ng Physician: To the best I Examiner: On the basis and manners	of examinat											
	Vithir To th comp	Me	29b. Signature and title of certific	er DID	,	2		c. License					signed (A			
				W/Cod	o NI	/	-	M	7610			1	well	52	5 00,8	
			30. Name and address of person David Tardio	, MD Calve	ert Me	dical	Print) Offic	ce Bi	ldg.,	Prin	nce Fre	deri	ck, M	D 20	678	
	Sta Regist		31. Date filed (Month, Day, Year	Regis	trar's Sig	ure	4									-

				1- State of Maryland / Department of Health and I Certificate of Death		iene 0 0 6	11221
		Physic	ion	1. Decedent's Name (First, Middle, Last)	2. Date of Death		3. Time of Death
		/Medi		Jean Chappell Benson	March	22 2000	0 9:20 pm
		Exami	ner	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	h	4c. County of Dea	th
				5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year   If Under 24 Hrs.	ne	Dome	rset
		Funeral Director		258-07-8228 1 M 2 K F 92 Yrs. Months Days Hours Min.	(Month, Day,	Year) Co	thplace (State or Foreign ountry)
				Usual Residence of Decedent	05/13/1	913   Tex	as
		show	_	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
		88-1:	Director	MD Somerset Princess Anne			1 ☐ Yes 2/X No
		with t	급	10e. Street and Number 10f. Zip Code	10	Og. Citizen of What Co	ountry?
		leeth	eral	9725 Arden Station Road 21853  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (St	nooity Von or No	USA 14. Race - Ame	riana ladian
	(0	ours after deeth with the Maryla ral', or Items 23a or 28e-f sho Examiner must be molffed a	Funeral	Armed Forces? If Yes, specify Cuban, Mexican, Puerti	o Rican, etc.)	Black, White	
	21215-0036	filed within 72 hours after deeth with the Maryland Hygiene. uther than "natural", or Items 23a or 28e-f show ant, the Madical Examiner must be notified at	by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:		Specify:	Thite
	5-0	72 hours "natural", olesi Exa	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	kina 1	16b. Kind of Business	
	121	d within 7. Jiene. r than "n	mpi	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)	9		
		e filed within the Hygiene. other than vent, the M	မ င	12 none Homemaker  17. Father's Name (First, Middle, Last)  18. Mother's Name	ne (First, Middle, M	Own Ho	me
	Maryland	e = 0 %	To Be	73 4 61 11		alden Sumame)	
	ar.	should be nd Mental marked c	F	E.A. Chappell Electa  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru		City or Town. State.	Zip Code)
7		alth a		William Benson/Son 31648 Mitchell Road, P	rincess	Anne, MD 2	1853
Ö	ore	es 1 g of He fiterr r oth		20a. Method of Disposition 20b. Place of Disposition (Name of		Oc. Location · City or	
5	Ĕ	Pag ment ant: I		gazana 2 garanasan a garanasan atau	25/2006	Princess A	nne, Marylar
1:25pm	Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other traumatic evonce.	1	1. Signature of Funt and Address of Facility.  Hinman Funeral Home	2		,,
0		# # # # # # # # # # # # # # # # # # #		MOO295 11673 Somerset Ave.	Prince	ss Anne, M	D 21853
_			1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or hear failure. List only one cause on each line.	or respiratory arres	st,	Approximate Interval Between Onset and Death
		Pnysician / /Medical	100	Immediate Cause (Final disease or condition resulting in death)			Orisist and Death
		Examiner		Due to (or as a consequence of):			
			ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  b. Due to (or as a consequence of):			
0		outed d ansit	Examiner	cause. Enter Underlying Cause (Disease of ilijury that initiated events  C.			
	o,	e exer ien ar irial-t	Ex	resulting in death) Last Due to (or as a consequence of):			
2/6	68760,	icate be executed physicien and s the burial-transit	dicai	d			
7	9 X	E On es	Мес	IF FEMALE:			
N	Bo	w requires thet the death certification is signed by the attending should be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ □ Fetal death 3 □ Ectopic pregnancy		23d. Date of del Month	very Day Year
_	o.	the de	nysic	1 ☐ Yes 22 No 4☐ Pregnant at time of death 5 ☐ Other (specify)9 ☐ Unknown			
5	σ,	s thet the ned by the detache	y Pt	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
$\Xi$	rds	quires			1 🗆 Yes	: 2 <b>/</b> No 3 □ Pr	obably 4 Unknown
2	Vital Record	aw re	Completed		24a. Was an	24b. Were au	topsy findings available completion of cause of
8	B	ysician: The lav is certificate has director, page 2 s	mo:		autopsy performe	eq death?	completion of cause of 2 No
S	/ita	ılcıan: Th certificate rector, pag	Be (	25. Was case referred to medical examiner? 26. Place of Deat	th (Check only one)		
. 2	of		P	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residen	ice 6 □Other (Spec	eify)
う		After uner	ion	27. Manuer of Death  1 Natural 5 Pending (Month, Day Year)  2 Accident investigation  28a. Date of Injury 28b. Time of Injury Work?  Work?  1 Yes 2 No	28d. Describe how	v injury occurred	
	Division	l or Attandi after death. Diractor: A I in by the fu	ficat	3 Suicide 6 Could not be 28e. Place of Injury - At home farm street factory office	28f Location (Stre	eet and Number or Ru	ral Pouta Number
	Ď	205	Certification:	4 Homicide determined building, etc. (Specify)	City or Town,	State)	ar rioute rumber,
		To the Hospitel of within 24 hours at To the Funeral D completely filled in	Medical C	29a. Certiflier  (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and manner stated.	and due to the cau red at the time, date	ise(s) and manner as e and place, and due	stated. to the cause(s)
		To the To the Comple	Me	29b. Signature and title of certifier 29c. License number	290	d. Date signed (Month	, Day, Year)
				) Notes 7 947094		3/23/06	,
	_			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Vel NAKSAN 1415 S-DIVISION ST. SAL	15BURY	3/23/06 Mg 2/	801
		Sta Registra		31. Date filed (Month, Day, Year)  MAR 2 8 2006  32. Registar's Signature			
		3,000		MIMIL IN O COOP PROPERTY ST. LANDER			

			For State Registrar	State of M	aryland		artment of H		Mental Hygi	ene	6 I	1222
4	i ĝi		Decedent's Name (First, Middle, La	st)					2. Date of Death			3. Time of Death
1	Physici /Medi		Wai	nza L. Bow	ers				March	24 2	2006	8:20 P <sup>M</sup>
3	Examir		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, or	Location of Dea	ath	4c. County	of Death	
		戲	Charlestown				Catons			Bal	timo:	re
	Funeral		5. Social Security Number 6. S	DM 357E	јө (In yrs. ias	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir	. (Month, Day,	Year)	9. Birthp	lace (State or Foreign try)
30	Director		Usual Residence of Decedent	8	:7	113.			Feb 23,	1919	West	: Virginia
	yłanc		10a. State 10b. County		10c. City, 7	Town or Lo	cation				1	0d. Inside City Limits
	a-f s	ctor	MD Baltim	ore	Cat	onsv	ille					1 ∐Yes 2 🛣 No
	if the	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of V	What Coun	try?
	ath w		719 Maiden Choice	e Lane			212	28		United	Stat	ces
	er de	Funerai	11. Marital Status	12. Was Decedent Armed Forces?		13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? ( n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		e - Americ	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐X If Yes, Give Year or Dates:	No		☐Yes 21XNo	Specify:		Specify	<i>/</i> :	
21215-0036	n 72 hours after death with the Maryland "natural", or Items 23e or 28e-1 show edical Eventivet must be revilled at	ed	15. Decedent's Ed	L .	1	16a. Deced	ent's Usual Occupa	tion	1.1	6b. Kind of Bu	Whi	
215	C "_ 0	Completed	(Specify only highest gra	de completed) College (1-4or 5		(Give	kind of work done di OO NDT use retired)	uring most of we	orking	ob. Kilid of Bu	12111622/1110	lustry
21	75 -	Com	12	College (1-40)	2+1	Book	keeper		M	anufac	turer	/Distribut
b	be filed ital Hygid of other event, I	Be	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle, Ma			, = ========
Maryland		T <sub>O</sub>	Hiram Jesse Sizer	more				Lettie	Ann McCar	ty		
<b>Jar</b>	C1 60 60		19a. Informant's Name/Relationship (						lural Route Number,			
	s 1 and 3 Health item 27 other tr		Charles W. Bowers	s/Son	001-01				ourt Ellic			
Baltimore,	Pages nent of H		20a. Method of Disposition 1 Burial 2 Cremation 3 5				sition (Name of atory or other place	. 1		Oc. Location -		
ij	permit. Pa Departmer Important any injury		4 Donation 5 Other (Specify				Mem. Gard			rincet		
Ba	permit. Pages Department of I Important: If its any injury or o once.		21. Signature of Funeral Service Licen	so- litel	M0104		Name and Address .12 Old Co	s of Facility Ha Dlumbia	arry н. Wi Pike Elli	tzke's cott C	Famı ity,	ly FH Inc. MD 21043
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lin	the death. [	Do not ente	r the mode of dying	, such as cardia	ic or respiratory arres	t,		Approximate Interval Belween
	Physician		Immediate Cause (Final disease or condition	meters	totic	to	east C	11100-				Onset and Death
2	/Medical Examiner		resulting in death)	Due to (or as	a consequen	ice of):	- ay / C	arcer	·			
	LAditiilei		Sequentially list conditions,	b								
	ed sit	nine	day, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequen	ce of):						
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequen	ce of):		_			_	
58760,	sician buria	alE				00 017.						
687		edical		d							Wei/	
Box	death certifi e attending id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy					23d Date	e of deliver	v
	200	icia	in the past 12 months?	1☐Live birth 4☐Pregnant at			Ectopic pregnancy Other <i>(specify)</i>			Mor		Day Year
P.0	at the de by the a tached	hys	9 ☐ Unknown	9□ Unknown						-		
	The law requires that the tite has been signed by thoage 2 should be detached.	by F	Part II. Other significant conditions co	ontributing to death bu	ut not resultin	g in the un	derlying cause giver	n in Part I.	23e. Did toba	cco use contr	bute to the	cause of death?
ord	w requir been s should	ted	Dementa						1 □ Yes	2 🗆 No	3 Proba	bly 4 Dinknown
ec	e law r has be je 2 sh	Completed							24a. Was an autopsy	24b. V	Vere autop	sy findings available pletion of cause of
<u>=</u>		Con							performe	d? d	eath?	
Vital Records,	ertific sctor,	Be	25. Was case referred to medical examiner?						ath Check only one			
	£ = =	2	1 165 2 2110	Hospital:			3□ DOA Other	4X Nursing F	dome 5 Residence			
Division of	ding Phy	on	27. Manner of Death  ∑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 281	b. Time of Injury	28c. Injury a Work?		28d. Describe how	injury occurre	ed	
Sic	Attender death rector:	icat	2 Accident investigation 3 Suicide 6 Could not be		int. At home	form stee		es 2 No	201 1			
É	after Direction by	Certification:	4 ☐ Homicide determined	28e. Place of Inju building, etc	: (Specify)	, rarm, stre	et, ractory, office		28f. Location (Stree City or Town,		or or Hurai	Route Number,
	Hospital 4 hours a Funeral ( tely filled		29a. Certifier 1 X Certifying Phy	sician: To the best o	of my knowled	dge, death	occurred at the time	date and place	and due to the cau	so(s) and may	nor ac eta	lad
	To the Hospital or Attentwithin 24 hours after deall To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Exam	iner. On the basis of and manner sta	examination	and/or inve	estigation, in my opii	nion, death occi	irred at the time, date	and place, a	nd due to	he cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier				29c. License	number	29d	. Date signed	(Month, D	ay, Year)
)			Denoin 1	Ben Pi	in	10	044	372		March	27,	2006
2	,		30. Name and address of person who c	ompleted cause of de	eath (Item 23	a) (Type, P	rint) Deneci	1 Bou	lin, mo		•	
W			711 Mariden C	have ha	ne,	Cut	nsville	, m	0 2122	8		
	Stat Registra	~	31. Date filed (Month, Day, Year) MAR 2 8 2	32. Redistra	r's Signature	L .	,	t				
6.	negistra	4	mm & 0 Z	.000	mer 10	× A	marke.					

			For State Registrar	State of M	aryland / D	epartmer Certifica			nd Me	ental Hy	/gien		u-relations	223
			Decedent's Name (First, Middle,	Last)						2. Date of D	eath		3. Ti	ime of Death
	Physic /Medi		Cheryl Louise	Butterfield	1_				N	Month Iarch	26. Da			35 P M
	Exami		4a. Facility Name (If not institution,			4b. City	, Town, or	Location of				. County of De		. 33 1
			Casey House			Rock	cville	е				ntgome		
	Funeral		Social Security Number		je (In yrs. last birth	day) If Unde	r 1 Year	If Under 2	4 Hrs.	B. Date of Bi (Month, D			Birthplace (S	State or Foreign
ь.	Director		184-40-2727	1□M 2X1F	55 Y	rs. Months	Days	Hours	Min.	$ \sqrt{Month}, D \\ \text{June} 1 $	ay, Year, 2 • 1	950 Pe	Cou <i>ntry)</i> nnsv1v	ania
2			Usual Residence of Decedent		1								, , , , , , , , , , , , , , , , , , ,	
2	or 28a-f show	_	10a. State 10b. County		10c. City, Town	or Location								ide City Limits
2	- 4	5	Maryland Montgom	ery	Olney								10	]Yes 2. ☐XNo
Ē	or 2	늗	10e. Street and Number			10f. Zij	p Code				10g. Ci	tizen of What	Country?	
£	23a	la l	18237 Paladin Dr	ive		208	332				USA			
d 21215-0036 filed with the Maryland	E S	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Dece If Yes, spe	dent of His	panic Origi	in? (Spec	fy Yes or N	0-	14. Race - Ar Black, WI		an,
36	5		1 ☐ Never Married 2 ☐ Married	If Yes, Give	No	1 ☐ Yes		Specify:	· donto i ii	oun, o.o.,				
00	E W	d by	3 Widowed 4 Divorced	Year or Dates:								Specify: Wh:	ite	
5.2	nat dien	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. C	Decedent's Usu Give kind of wo life. DO NOT u	ial Occupat ork done du	tion <i>uring</i> mo <i>st (</i>	of working	,	16b. K	ind of Busines		
12 j	than	Ę.	Elementary/Secondary (0-12)	College (1-4or	0+)									
7	tygic nt, ii	ပိ	17. Father's Name (First, Middle, La	4	Reg	istered						1thcar	2	
and	ntai od o	Be	Clair Rodney Bee							First, Middle				
aryla should !	d Me mark matic	2	19a. Informant's Name/Relationship		405.4	4 22 4 4 4				nor B				
Baltimore, Maryland 21215-0036	Depertment of Health and Mental Hygiene. Importent: if Itam 27 is marked other than "natural", or Items 23a or 28a-f eho any injury or other traumatic event, the Madical Examinar must be multiled at once.	n i	Darrell Butterfi		182	Mailing Address 37 Pala	s (Street ar ad in T	nd Number )rive	Of Rural I	Route Numb	er, City o 2∩8	or Town, State 39	, Zip Code)	
<b>9</b> - g	Heal am 2 ther		20a. Method of Disposition		20b. Place of D			TIVE	Dat	-				
See see	or or		1 ☐ Burial 2 TCremation 3		cemetery,	crematory or o	other place	)   N	1arch	. 28,	20c. L	ocation - City o	or Town, Sta	ite
i i	rtme rtent rent		4 Donation 5 Other (Spe		Chesap	eake Cr			2006		Be1	tsville	e, Mar	yland
Balt	Depe impo any i	J. 1	21. Signature of Funeral Service Lice	111		Going	nd Address Home	of Facility Crema	ation	Serv	ice	P.O. I	3ox 78	34
			23a. Part1. Enter the disease, or co		MO1251	Bever1	v L.	Heckr	otte	. P.A	. C1	arksvi	Lle, M	D 2102 kimate
E	Medical and street it is the purial-transit	al Examiner	Sequentially list conditions, if any, beauting to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	tic Cance a consequence of) a consequence of) a consequence of)	k								
ords, P.O. Box 68760, requires that the death certificate be executed	by the ettending tached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at 9□Unknown	2 Fetal death time of death	3 □Ectopic pr 5 □ Other (sp	ecity)					23d. Date of d Month	elivery Day	Year
ds th	signed be de	by	Part II. Other significant conditions	contributing to death be	ut not resufting in th	ne underlying c	ause given	in Part I.				se contribute		
orc lequi	been si should	ted								10	Yes 2	ZNo 3□F	Probably 4	4 Unknown
Division of Vital Records, or Attending Physician: The law requires t	has 96.2	Completed							<u> </u>			prior to death?	completion	ings available of cause of
of Vita Physician:	is certificate director, pag	Be (	25. Was case referred to medical examiner?				2	26. Place of	f Death (C	check only o		1		
Fys.	this or	၉	1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatie	nt 2 ER/Outpa	atient 3 DO	Other:	4 🗌 Nursi	ing Home	5 🗆 Resid	dence (	Other (Sp.	ecity) Ho	spice
<b>5</b>	e life	ë	27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Tim Year) Inju	e of 2	8c. Injury a Work?	it		f. Describe I				
Vision	or: A	Certification:	2 ☐ Accident investigati			М		s 2 No	)					
ĭŽ ₹	irect irect	Ě∥	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ry - At home, farm	, street, factory	, office		28f	Location (S	Street an	d Number or F	Rural Route	Number,
	raf D			1										
Hosp	within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical	(Silver Silvy Z   Medical Ex	hysician: To the best of	examination and/o	eath occurred	at the time,	date and p	olace, and	due to the	cause(s)	and manner a	s stated.	Isa(s)
- £	hin 2 the	Med		and manner sta	ted.				20001160					
٩	S O W		29b. Signature and title of certifier	~ ×	~~		. License n				29d. Dat	e signed (Mon	th, Day, Yea	ar)
Jones .	_						35635			M	larch	27, 2	006	
€.	6-1		30. Name and address of person who											
			Joseph Kaplan M.	D. 6001 Mu	ncaster M	fill Rd	. Roc	kvill	e, M	2085	55			
	Star Registra	e ar	31. Date filed (Month, Dar Year) 8	2006 32. Resistra	r's Signature	Louis								

State of Maryland / Department of Health and Mental Hygiene State Amend #32per Frederick Co. Healthicareport. Death CNM 03-27-2006 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** GENEVIEVE CROSBY BETTS MARCH 25 2006 10:18PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 16776 WHITE STORE RD. BOYDS MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day APR 21 Birthplace (State or Foreign Country) **Funeral** Months 045-32-9650 90 Yrs. Director CANADA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show rai', or iteme 23a or 28a-f ehov Examinar must be notified at MD MONTGOMERY BOYDS Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 16776 WHITE STORE RD. 20841 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No WHITE Specify: þ 3 Widowed 4 ☐ Divorced ear or Dates: "natural" Completed other then "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TOWN LIBRARY LIBRARIAN / WRITER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PERCY CAREY and Mental ie marked FRANCES CROSBY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN de MESSIERES/DAUGHTER 16776 WHITE STORE RD., BOYDS, MD 20841 Health tem 27 t 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location · City or Town, State 3/28706 ± 5 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. FREDERICK CREMATORY FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fyneral Service Licensee 22. Name and Address of Facility
HILTON FUNERAL HOME P.O. BOX 86, BARNESVILLE, 20838 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner CR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Records, P.O. Box 68760, Physician/Medical use as attending for use as 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 4☐Pregnant at time of death signed by the a d be detached for 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by been si 1 Tyes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate hes birector, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 1 Yes Be To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death | Check only on. examiner? 1 Tes 25 No Hospital: 1 🗌 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Injury 5 Pending 1 Yes 2 No 2 Accident investigation 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ŏ To the Hospital within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0660548 3/27/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS ODAR, MD 15225 SHADY GROVE RD., ROCKVILLE, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

		ļ	4	epartment of Health and N Certificate of Death	fental Hygien Reg. K	ZHHK	11225
	Physici	an	Decedent's Name (First, Middle, Last)  MADNA CHID TOTALLY A DOLLMAN		2. Date of Death Month MARCH 23	Day 2006	3. Time of Death
}	/Medic	cal	MARY CHRISTEVA BOWMAN  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	L	4c. County of Death	4:00 A M
i	Examin	ier	SHADY GROVE ADVENTIST HOSPIT			MONTGOME	ERY
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	ar) Coui	
	Director		219-34-9665 91 Usual Residence of Decedent		DEC 24 1	914	VA
	arylan show	ř	10a. State         10b. County         10c. City, Town of MONTGOMERY         BOYDS				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the M	Director	10e. Street and Number	10f. Zip Code	10g. C	Citizen ol What Cour	
	th with 23a or	ai Di	20525 BUCKLODGE ROAD	20841		USA	
0036	be filed within 72 hours after deeth with the Maryland at Hygiene. All Hygiene deeth with the Maryland at other than "natural", or items 23a or 28e-f show event. In Madical Exam car must be notified at svent.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 20 No If Yes Give Year or Dates:	<ul> <li>13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto</li> <li>1 ☐ Yes 2 No Specify:</li> </ul>	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: WH	etc.
7-0-2	within 72 ho ene. then "natur	Completed	(Specify only highest grade completed) ((	recedent's Usual Occupation Give kind of work done during most of work ite. DO NOT use retired)	ing	Kind of Business/In	ndustry
7	filed wi Hygien other th		5 CUS	STODIAN 19 Matheda New	e (First, Middle, Maid	EANING	
yland		To Be	JOHN THOMAS GRIFFIN		GRADY	Bn Sumame)	
Mar	s 1 and 2 should f Health and Mer itsm 27 is marke other treumatic			Mailing Address (Street and Number or Rui 525 BUCKLODGE RD.	•		о <i>Code)</i> 8 <b>41</b>
ē,	of Hea		20a. Method of Disposition 20b. Place of D	and sometimes are the control of the	Date 20c.	Location - City or To	
	permit. Pages Depertment of I important: If its any injury or o once.		4 □Donation 5 □Other (Specify) FORES 1	OAK CEMET. 3/27		ITHERSB	URG, MD
Balt	permit. Par Depertment important: any injury once.		21. Signature of Funeral Jerikos Liturisee	22. Name and Address of Facility HILTON FUNERAL H P.O. BOX 86, BAF	IOME RNESVILLE	, MD 2	0838
			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	t enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval 8etween Onset and Death
Å	Physician /Medical		disease or condition resulting in death)  SEPSIS  Due to (or as a consequence of	):			
	Examiner		Sequentially list conditions b. URINARY TRACT	INFECTION			
	nsit	Examine	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury	j.			
ĵ	icate be executed physicien and s the burial-transit		that initiated events resulting in death) Last C.  Due to (or as a consequence of	):			
8/PD	cate be physici the bu	dical	d				
g ROX ROD	certii ding se a	0	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	- 1 000		23d. Date of deliv	/ery
	the death y the atter ached for u	Physician/M	in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
as, r	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in t  ACUTE RENAL FAILURE	he underlying cause given in Part I.	23e. Did tobacc	co use contribute to t	
Hecords	law requast been 2 shoul	ojete	ATRIAL FIBRILLATION		24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
	The ate h page	Completed			autopsy performed	? death?	
VITal	Physician: Th this certificate rat director, pag	Be	25. Was case referred to medical examiner?	Other	th (Check only one)		
Ö	Phys this rat did	lon: To	27. Manner of Death 1 Vinipatient 2 Product 28a. Date of Injury (Month, Day Year) Inj	ne ol 28c. Injury at work?	ome 5 Residence 28d. Describe how in		r(ty)
DIVISION	Atten sc deal sctor by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larn building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No n, street, factory, office	28f. Location (Street City or Town, St.		ral Route Number,
_	Hospital or 24 hours afte Funeral Dir tely filled in		29c Certifier 15 Certifying Physician: To the best of my knowledge. (Check only 2 Medical Examiner: On the basis of examination and/	Jeath occurred at the time, data and place	and due to the cause	(s) and marner as:	Stated to the cause(e)
	\$ <b>5 5 6</b>	Medical	one) and manner stated.	29c. License number			
-	Son Twit			D0061681	3	Date signed (Month, 3 / 23 / 200	6
1	0)	-	30. N me and address of person who completed cause of death (Item 23a) (TROBERT KIRKCALDY, MD 9901 MEI	ype. Print) DICAL CENTER DR.,	ROCKVIL	LE, MD	20850
ı	Sta Registi		31. Date liled (Month, Day, Year) MAR 2 7 2006 32. Registrar's Signature				

			rieas	State of M				Health and	-		_		
			1 - For State Registrer	State of M	arytario		tificate of			Reg. No.		112	26
			Decedent's Name (First, Middle	, Last)					2. Date of Dea			3. Time o	f Death
	Physici /Medio		Constance Virg	ginia Clagge	ett				March	27	, 2006	2:15	Ам
	Examir		4a. Facility Name (If not institution, Heartland, Healt)	give street and number)	of		4b. City, Town,	or Location of Deat	h	4c.	County of Deat	h	
			Hyattsville			ant himbolay	Hyattsv ff Under 1 Year		O Data of Bio		rince G	eorges	or Comins
	Funeral Director		5. Social Security Number 577–66–6343	6. Sex 1 ☐ M 2 X F	10 (In yrs. 12 72	ast birthday) _ Yrs.	Months Days	Hours Min.		n y, Year)	933 Mai	hplace (State ountry) ryl.and	or Foreign
			Usual Residence of Decedent						100 L. 13	), <u>1</u>	מיז   כככ		
	arylan show	_	10a. State 10b. County	G	1	, Town or Loc	ation					10d. Inside C	ity Limits 2X No
	he Ma	Director		e Georges	Ade]	Lpn1	101 71 0-1			10- 03			2,4,140
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiens. I them 27 is marked other then "natural, or Items 23 so or 28e-f show other treumatic event, in a Madical Examinating the indilited at	Ö	10e. Street and Number 7980 New Riggs	Road, #112			10f. Zip Code 20783			rog. Citi	u. S.		
	death	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13. W	as Decedent of	Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No	-	14. Race - Ame		
o	or Ite		1 Never Married 2 Marri	Armed Forces? 1 ☐ Yes 2 [X] If Yes, Give			Yes, specify Cub ☐ Yes 2 🔀 No		to Hican, etc.)		Bfack, Whit	•	
0500-61717	ural',	d by	3 Widowed 4 Divorced	Year or Dates:					1				
<u>.</u>	n 72 t	Completed	15. Decedent (Specify only highes	t grade completed)		16a. Decede (Give k	ent's Usual Occu ind of work done O NOT use retire	pation during most of wo ed)	rking	16b. Ki	nd of Business/	Industry	
7 7	iene. jene. r then	omp	Elementary/Secondary (0-12)	College (1-4or	5+)		sewife	,		Home	۵		
	e filed within al Hygiene. other then "	BeC	17. Father's Name (First, Middle, L	ast)			,CWIIC	18. Mother's Na	me (First, Middle,				
yland	should be ind Mental s marked o umatic eve	To	Ernest T. Clage	gett			0		Whalen				
<u>0</u>	2 sho		19a. Informant's Name/Relationsh Helen Hatcher					t and Number or Ru					
บ้	1 and Health em 27 ther t		20a. Method of Disposition	daugiicei	20b. PI		New Rigition (Name of atory or other pla	gs Rd., #	Date Date		cation - City or		
Бант	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tre		1 Burial 2 Cremation '4 Donation 5 Other (Sp	3 Removal from State				!	1 /06		•		
	mit. Poartme oorten injur		21. Signature of Fungral Service L		Met			natory 4/			<u>andria,</u> son Fun		ome. P
ŏ	Depa Impo		Judith 9	Johnse				Branch Av					
			23a. Part . Enter the disease, or shock, or heart failure. List of	complications that cause only one cause on each li	d the death	. Do not ente	r the mode of dy	ing, such as cardia	c or respiratory ar	rrest,		Approxima fnterval Be	tween
į	Physician		fmmediate Cause (Final disease or condition	_ a	_			L SEP				Onset and	Death
	/Medical Examiner		resulting in death)	Due to (or as									
ь		e.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as	a consequ	ence of):							
	od d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
Ď,	be executed ician and burial-transit		resulting in death) Last	Due to (or as	a consequ	ence of):							
00/8	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Ilcal		d									
X DX	The law requires that the death certificate tte has been signed by the attending phys age 2 should be detached for use as the	Physiclan/Med	IF FEMALE:	23c. If yes, outcome	of oregnar	ncv					22d Data of dal	i von	
Ž Q	atten I for u	clan	23b. Was decedent pregnant in the past 12 menths?	1☐Live birth	2 Fetal	death 3 1	Ectopic pregnand Other (specify)	СУ		'	23d. Date of del Month		Year
j.	the d by the ached	hysi	1 ☐ Yes 2 Ø No 9 ☐ Unknown	9 Unknown									
νς. Σ	s that gned t	by P	Part II. Other significant conditio		out not resu	tting in the un	derlying cause g	ven in Part I.	23e. Did to	obacco u	ise contribute to		
ä	equire en siç ould b		DUEWI	4					101	Yes 2	□No 3□Pr	obably 4	Unknown
Vital Records,	law r las be	ompleted	RENAI	L FAILURI	3				24a. Was autop	osv	prior to	topsy findings completion of c	available cause of
	: The cate h	Con								med?	death? 1 ☐ Yes	2 🗆 No	
2 2	rding Physicien: The law th. : After this certificate has b funeral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:			0:		ath (Check only o				
	Phy	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Inju	ıry	ER/Outpatient 28b. Time of	3L DOA 28c. fnju	a Nursing F	dome 5 Resid		-	city)	
0	Attending r death. sctor: After sy the fune	atlor	1 Natural 5 Pending 2 Accident investig		y Year)	Injury		ork? ]Yes 2 []No					
DIVISION	l or Attendi after death. Director: A I in by the fu	Certification:	3 Suicide 6 Could n 4 Homicide determi		jury - At hor tc. (Specify	me, farm, stre	et, factory, office		28f. Location (S City or Tov		d Number or Ru	ural Route Nun	nber,
5	Itel or Irs aft rel Di												
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medical	29a. Certifier Certifying (Check only one)	g Physicien: To the best Exeminer: On the basis of	of my know of examinati	vledge, death ion and/or inv	occurred at the testigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time.	cause(s) date and	and manner as place, and due	stated. to the cause(	s)
	o the ithin 2 o the amplet	Med	29b. Signature and title of gertifier	and manner st	ated.			se number			te signed (Mont		
	F 3 F 8		· Yan		A.D.			005820			/29/0		
0	(1)		30. Name and address of person v	who completed cause of	death (Item	23a) (Type, F		03000			1-110	<u> </u>	
1	- U		SUR (FSIA KUMAI	2 MUTTATH	42	03 01	JEENSB	URY RD	· ISYAS	TSV	ILLE,	MD 20	781
	Sta		31. Date fifed (Month, Day, Year)  MAD 2 0 21	2. Regist	rar's Signat	Ure	et,						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** MARCH 2006 7:00 AM COLEMAN LEE SERUS /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** PRINCE GEORGE'S CRESENT CITIES NURSING HOME RIVERDALE 8. Date of Birth (Month, Day, Year) 1910 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1XM 2□ F Yrs 96 FEBRUARY 17 ALABAMA Director 416-22-0940 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director MD PRINCE GEORGE'S GLENARDEN 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 8631 GLENARDEN PARKWAY 20706 S.A. death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK þ 3 ™ Widowed 4 □ Divorced \*natural\* Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE FARMER 6th othar 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental H iant: If itam 27 Is marked other DAVIS SYLVIA MARK COLEMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If itam 27 Is
any injury or other trau 8631 GLENARDEN PARKWAY GLENARDEN MARYLAND 20706 JACKSON/DAUGHTER MARIE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 3/30/2006 SELMA, ALABAMA DOCK HENRY CEMETERY ⁴ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND 20706 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Artenio sclarote Candiovaswar Diseate years Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of: Examiner cause. Enter Underlying Cause (Disease or injury The faw requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last ding physician and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, been signe should be a Completed by 1 ☐ Yes 2. No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 2.210 といかったら 1 ☐ Yes the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ٥ 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: After 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). VORE MD 4203 G reens Registrar's Signature. 31. Date filed (Month, Day, Year) State MAR 2 8 2006 Registrar

		For	State of Maryland	d / Departme	nt of Health	and Me			11228
		State Registrar		Certifica	te of Deatl			og. Ño.	\$ 3 Ecolo Scoto NAP
Physici		Decedent's Name (First, Middle, Last)     JEANNE ELAINE COL	E				2. Date of Deat Month March 2	Day Year 23, 2006	3. Time of Death 8:00 a M
/Medic Examir	_	4a. Facility Name (If not institution, give st	reet and number)	4b. City	, Town, or Location	n ol Death		4c. County of Deat	th
	# ·	Doctor's Communit	y Hospital		nham			Prince (	
Funeral Director		5. Social Security Number 6. Sex 577-46-3083 1□	7. Age (In yrs. la 74	Ast birthday) If Und Months		er 24 Hrs. Min.	8. Date of Birth (Month, Day, July 8,	Year) 9. Bird 1931 Was	thplace (State or Foreign buntry) hington, DC
anyland show ed.et	٦	Usual Residence of Decedent  10a. State 10b. County	,	, Town or Location					10d. Inside City Limits 1 X Yes 2 □ No
the M 28a-1	Funeral Director	Maryland Prince G	eorge's Be	rwyn Heigh	ip Code		1/	0g. Citizen ol What Co	ountry?
with	2		a d		20740			U.S.A.	
eath	era	8802 Edmonston Ro	2. Was Decedent Ever in U.		edent of Hispanic C ecify Cuban, Mexic	Origin? (Spec	ify Yes or No-	14. Race - Ame	
irs after d if, or Item	by Fun	1 □ Never Married 2 □ Married 3 ሺ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates:	i i	ecify Cuban, Mexic 2X No Specif		lican, etc.)	Black, Whit	White
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Modical Examinar most be notified at once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	16a. Decedent's Us (Give kind of v life. DO NOT	ual Occupation rork done during me use retired)	ost of workin	g	16b. Kind of Business	/Industry
with piene r tha	E	12	College (1-401-54)	Housewif	e			Own Home	
i Hyg othe	BeC	17. Father's Name (First, Middle, Last)			18. Mot	ther's Name	(First, Middle, I	Maiden Surname)	
Ald be Alenta	To E	Walter H. Madison			Mi	lldred	I. Benn	nett	
shou and N	171	19a. Informant's Name/Relationship (Typ	pe, Print)	3	•			, City or Town, State,	
and 2 ralth a		Sally B. Miller -				7			yland 20910
oermit. Pages 1 ar Department of Hea Important: if item any injury or othe		20a. Method of Disposition 1 X Burial 2 Cremation 3 □Re	20b./P	lace of Disposition (Nemetery, crematory of	ame of other place)	1		20c. Location - City or	
Pagnent ant: f		4 □ Donation 5 □ Other (Specify)	Mar	,		F			n, Maryland
port		21. Signature of Funeral Service License						neral Home	
897 2 2 9		23a. Parti, Ent if the disease, or complice shock, or lear failure. List only on	11/09/					tsville, M	D 20761 Approximate
death certificate be executed  /Medical Examine e ettending physicien and ad for use as the burial transit	ical Examiner	Immediate Curse (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Adeno Carcin Du o (or as a consequence Renal Failur Due to (or as a consequence Anemia Due to (or as a consequence Consequence	uence of): Ce uence of):					
eath certificate ettending phys	Physician/Medical	in the past 12 months?	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	I death 3 ☐ Ectopic				23d. Date of de Month	elivery Day Year
hat the did by the dietached	lysi	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9☐ Unknown		, ,,			- 11	
	Ď	Part II. Other significant conditions con	tributing to death but not res	ulting in the underlyin	g cause given in Pa	art I.		bacco use contribute fes 2 □ No 3 □ F	to the cause of death? Probably 4 ∭Unknown
or Attending Physician: The law requires taffer death.  Director: After this certificate has been signe in by the funeral director, page 2 should be	Completed						24a. Was a		utopsy findings available
ne fav s has ge 2	E						autop: perfor 1 Tes	sy prior to med? death?	
iician: Th certificate rector, peç		OF Was one referred to modical			ac Di	age of Death	Check only or		s 2 No
ysician: The is certificate hi director, pege	o Be	25. Was case referred to medical examiner?  1 \sum Yes 2 \sum No	lospital: 1 🕅 Inpatient 2 🗆	FR/Outnationt 3	Othor			ence 6 Other (Sp.	ecify)
Attanding Physician: ir death. ector: After this certifici by the funeral director.	⊢	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time ol	28c. Injury at Work?			ow injury occurred	- 31
th: After s funer	tio	1 XNatural 5 Pending 2 Accident Investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2	No			
or Attene after deatl Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, fact y)	ory, office	2	281. Location (S City or Tow	Street and Number or F in, State)	Rural Route Number,
Hospita 4 hours Funeral	edicai C	29a Certifier 1 Certifying Physical Concept 2 Medical Examination	sician: To the best of my knoner: On the basis of examina and manner stated.	owledge, death occurr ation and/or investigat	ed at the time, date on, in my opinion, o	and place, a death occurre	and due to the dead at the time, o	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
To the within 2 To the complet	₩ W	29b. Signature and title of certifier	1 A	1. 11 n	29c. License numb	er		29d. Date signed (Mor	
		I How H	E Mys	Li M.D.	D59993			3,24,	05
) h	)	30. Name and address of person who co	empleted cause of death (Iter	n 23a) (Type, Print)					
- (g)		Amirali Amjadi,	MD 8118 Good	d Luck Roa	d, Lanhar	n, Mar	yland 2	0706	
St	tate trar	31. Date filed (Month, Day, Year) MAR 2 8 2006	. Registrar's Signa						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month March 1**9** 2006 Physician 2:00 P M Ivey Ρ. Cooper /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery 16112 Crabbs Branch Way # 24 Derwood | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. | 12, 1927 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Highpoint, NC 1 □ M 2√2 F Aug. 78 Yrs. 107-18-3253 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "nature!" ..." ey injury or other treumatic events. 10d. Inside City Limits 10c. City, Town or Location 10h Count 10a State X Yes 2 No Derwood MD Montgomery Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 20855 United States 16112 Crabbs Branch Way Apt #24 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 🛣 No Specify: Completed by 3 Widowed 4 NDivorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) Restaurant Cashier 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Gladys Fletcher Eugene Beane 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 218 Sommerset Street Ocean City, MD 21842 Brian Lingrell (SON) 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Fort Lincoln Crematory 3/28/2006 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MD 20722 franco uran 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final Frysician Coronary Artery Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Hyperlipidemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hypertension The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Arrythmia Physician/Medical the IF FEMALE: esu. 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetaf death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No
9 Unknown for 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. the 9 Unknown ģ signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 ☐ Probably 4 Munknown Severe anxiety, possible schizophrenia, 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? Dyskenesia second degree to Neuroleptics in the past 24a. Was an autopsy has page 2 1 ☐ Yes 2 ☐ No 1 ☐ Yes XXNo certificate Division of Vital Hospital or Attending Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Cther: 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA XXYes 2 □ No 2 this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28a. Date of Injury After t Certification: (Month, Day Year) 5 Pending investigation X□ Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after death • Funerel Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number and title of certifier 29b. Sig 30. Name and address of person who completed cause of leath (ftem 23a) Two Public Gaithersburg, MD 20573 16220 Frederick Road Christikn Nwkankwo Jr. M.D.

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 2 8 2006

2. Registrar's Signature

			For State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F			iene No. 006	11230
	Physicia	45	Decedent's Name (First, Middle, Las     Paul Raymond	Cahill				2. Date of Death Month March 2	Day 2006	3. Time of Death 2:52 a M
1	/Medic Examin		4a. Fecility Name (If not institution, give Suburban Hospita			4b. City, Town, o	r Location of Death		4c. County of Deat	
	Funeral Director		521-74-3385	ex 7. Age	55 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 8,	Year) Co	hplace (State or Foreign unitry)
	e Maryland	ctor	Usual Residence of Decedent           10a. State         10b. County           Maryland         Montgo	omery	10c. City, Town or L					10d. Inside City Limits 1 ☐ Yes 2♣No
	th with the	ai Director	10e. Street and Number 4115 Mitscher Cou	ırt		10f. Zip Code 2089	95	10	0g. Citizen of What Co USA	ountry?
036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or itema 23a or 28a-f ehow important: If item 27 is marked other than "naturel; or itema 23a or 28a-f ehow entry injury or other traumatic event, I're Madical Examination and the nutilized at once.	by Funeral	11. Marital Status 1 □ Never Married 2점 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 16 N If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 2 No	dispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: WI	
Maryland 21215-0036	i within 72 ho liene r than "natur Ine Madical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed)  College (1-4or 5	+) (Give	dent's Usual Occup a kind of work done DO NOT use retired ogram Ana	during most of work d) _	ing	16b. Kind of Business/ United Sta Governmen	ates
and	d be filed antal Hyg ced othe c event,	Be	17. Father's Name (First, Middle, Last) Harry Paul Cahil	_	, ,		18. Mother's Name		Maiden Sumame) O'Connor	
Maryl	d 2 shoul th and Me 7 is mark traumati	To	19a. Informant's Name/Relationship (7						City or Town, State, 2	
Baltimore, I	Pages 1 and lent of Heali nt: If item 2 ry or other		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of Disp cemetery, cre		(e) Marc	Date 2	20c. Location - City or	
Balti	permit. Departm Importa eny inju		21. Signature of Funeral Service Licen		F 5	rancing Addre 00 Univer	ess corring csity Blvd	_		g, MD 20901
	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or com, shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, days. Enter Underlying Cause, Disease or injury	one cause on each lin  a. Melanoma  Due to (or as a	ie.	ter the mode of dyir	ng, such as cardiac	or respiratory arre	sst,	Approximate Interval Between Onset and Death 2 Months
8760,	icate be executed physician and s the burial-transit	dical	that initiated events resulting in death) Last	Due to (or as a	a consequence of):					
.O. Box 6	the death certity y the attending tched for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	□Ectopic pregnancj □ Other (specify) _	у		23d. Date of del Month	ivery Day Year
rds, P	Se OG	þ	Part II. Other significant conditions of	ontnbuting to death bu	ut not resulting in the u	underlying cause giv	ven in Part I.		oacco use contribute to es 2X No 3 ☐ Pr	the cause of death?
Il Records,	The law ate has b page 2 sl	Completed						24a. Was ar autopsy perform 1 Yes 2	y prior to death?	utopsy findings available completion of cause of 2 No
Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatie	nt 2 ☐ ER/Outpatie	nt 3(\$\frac{1}{2}DOA Oth	ner.	h (Check only one	e) ince 6 □Other (Spe	c/h/)
ion of	ding h. After fune	ation: To	27. Manner of Death  1 Sex Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Da)	y 28b. Time o	of 28c. Injur			w injury occurred	uny)
Division	or after or in the principle of the pri	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc	iry - At home, farm, si c. (Specify)	reet, factory, office		28f. Location (Str City or Town	reet and Number or Ri , State)	ural Route Number,
	he Hospital n 24 hours a he Funeral E pletely tilled i	edicai			examination and/or in				ause(s) and manner as ate and place, and due	
)	vithin 2 vithin 2 To the I	M	29b. Signature and title of certifier	ulh 9	Heisse	29c. Licens	se number 50050	58	9d. Date signed (Mont March	h, Day, Year) 23, 2006
	B		30. Name and address of person who Dr. Mahrukh Huss	ain Kais	ser Perman	ente- 139	6 Piccard	Drive,	Rockville,	MD 20850
	Sta Registi		31. Date filed (Month, Day, Year)  MAR 2 8	32. Agistra	ar's Signature	perke				

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

State Registrar

30

Prince

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0

32 Registrar's Signature

Bayel

hekma

31. Date filed (Month, Day, Year)

200G

olvey

Phillip Drive

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 13b State of Maryland / Department of Health and Mental Hygiene State Registrar WCHD/SH 3/30/06 per FH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** OVER 28 2016 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death Examiner BAITINIORS RAUMA CENTER HOCK 7 MORR If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Min 1 <del>M</del> 2□ F Yrs 69 Director 3/26/1937 204280197 PA Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. Count 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Franklin Greencastle 10e. Street and Number 10g. Citizen of What Country? 238 14045 177225 USA Completed by Funeral Mercersburg Road filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 ŏ 1 Yes 2 No Specify: Specify: White 3 □ Widowed 4 □ Divorced 15 Decedent's Education 16a Decedent's Usual Occupation 16h Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Pressman Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil tment of Health and Mental H tant: If item 27 Is marked off Be William D. Cover Lillian M. Mellott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17225 14045 Mersersburg, Peggy Cover (Wife) Rd. Greencastle, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 6 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 3/30/06 McConnellsburg, Pa. 22. Name and Address of Facility Howard Sipes Funeral Home 21. Signature of Funeral Service Licensee David L. Strelly h. #MU1035 875 Lincoln Way E. McConnell Solve, Pal723 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EXAMMER **Physician** smonths VER tai disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed G that initiated events resulting in death) Last Que to (or)as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, COLLISION 2) No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 Ø No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 200 No ) Rumo-HORA 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Øes 2 □ No 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ₺% VEHICLE COLLISION 10+02 24 hours after death. 2/CAccident investigation 23-06 729 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)
Grant Shook Rd + Canac Cheague Ln
Grence Sterph Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide Road Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) within 2 29b. Signature and title of certifier Mus

Registrar

State

/tonk

30. Name and address of person who completed cause of death-(Item 23a) (Type, Print)

			. For	State of Mai		d / Depa					•		e	DIC.	11000	
			1 - State Registrar			Cer	tificate	of L	Death			Reg. N	.U U	0	11233	
	Physici	an	Decedent's Name (First, Middle, Last,		_					2	2. Date of De Month		ay	Year	3. Time of Death	
	/Medic		TONY KEYSTER	CARR, S	R.						March			2000	4:15 a.	М
	Examin	er	4a. Facility Name (If not institution, give Memorial Hospi					~	Location of		4	4		of Death		
	Funeral		5. Social Security Number 6. Sec		(In yrs. la	ast birthday)	If Under 1		If Under 2			irth	711	9. Birthi	place (State or Foreig	ian
	Funeral Director			5M 200 E	69	Yrs.	Months	Days	Hours	Min.	(Month, D	12.1	936	WEST	place (State or Foreigntry) VIRGINIA	<b>3</b>
	P .		Usual Residence of Decedent		10- 07-	-										
	ehov	J.	10a. State 10b. County  WV MINER			, Town or Lo IDGEL									I0d, Inside City Limit 1 ☐ Yes 2 🛣 N	
	the M	by Funeral Director	10e. Street and Number	AD	11.		10f. Zip 0	Codo				10a C	itizan of l	What Cou		
	with with	Dir	ROUTE 3, BOX 2	9.4				675:	2				J.S.		nury :	
	me 23	lera	11. Marital Status	12. Was Decedent Ev	ver in U.S	6. 13. V				gin? (Spec	ify Yes or Nican, etc.)				can Indian,	
9	after or item	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No	D					, Puerto Ri	ican, etc.)			ck, White,	etc.	
ဗ္ဗ	ural',	d by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 □ Yes 2]	ŽI NO	Specify:				Specif	y: WI	HITE	
<u>2</u>	tied within 72 hours after deeth with the Maryland Hygiene, ther than "neturel", or terme 23a or 28a-f ehow oft, II a Musical Examinat main be notified at	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)		(Give	lent's Usual kind of work	done d	uring most	of working	7	16b. i	Kind of B	usiness/In	dustry	
12	withir ene. than	ошо	Elementary/Secondary (0-12)	College (1-4or 5+	-)		SSENC					F	IOSP	ITAI	ı	
<u>0</u>	Hygi other	Be Co	17. Father's Name (First, Middle, Last)						18. Mother	r's Name (	First, Middle	e, Maide	n Sumar	ne)		_
ılan	uld be Menta rrked tic ev	To B	ARTHUR CARR						VE:	LMA	PAULI	INE	WH	ITE		
Maryland 21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Marylen Depertment of Health and Mental Hygiene. Deportment of Health and Mental Hygiene. The marked other than "natural", or teme 23a or 28a-f show morpromit: if item 27 is marked other than "natural", or teme 23a or 28a-f show eny injury or other traumatic event, if a Medical Exacilitating it and the puttilised at once.		19a. Informant's Name/Relationship (Ty				-				Route Numb	-				
≥ ′	and lealth m 27 her tr		TONY K. CARR,	JR. / SO	,				D STI	REET	, KEY				26726	
Baltimore,	t of the		20a. Method of Disposition 1 ØBurial 2 ☐ Cremation 3 ☐ F	lemoval from State	ce	ace of Dispo	natory or oth	er place	- 1						own, State	
量	it. Pertant		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licers	904	DAV	WSON C				3/25/			AWSO	N, M	)	
Ba	Depermine Depermine Impo		Umma a	Poch.	00	_   "	UPCHU	RCH	FUNE	RAL H	OME, I	PAA	NID.	MD 1	21502	
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	idations that caused the	the death.	. Do not ente							ND/		Approximate Interval Between	
	Physician	8 1		End Stac		3 laws	is Ob	e L		0	المساء	- 100 4	n:ca	0060	Onset and Death	
	/Medical		resulting in death)	Due to (or as	consequ	ence of):	10 00	211	ucti	10 11	amen	Cr. 4	שואכו	MSE !	Cellellows	
	Examiner		Sequentially list conditions,	b												
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequ	ence of):										
	be executed icien and burial-transit	xan		Due to (or as a	consequ	ence of):								-		
760,	ate be executed hysicien and the burial-transit	calE		1												
.89	tificat og phy as th															
ŏ	th cer rendir r use	an/h	23b. was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2			Ectopic pred	onancy						te of deliv	*	
.O. Box	es that the death certifica igned by the ettending ph be detached for use as th	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at til			Other (spec				<del></del>		Mo	onth	Day Year	
<u>٦</u>	hat th d by detach	Phy	Part II. Other significant conditions con	atributing to death but	t not resul	Iting in the us	dorhing on	160 01110	o io Part I		23e Did	tobacco	LISA COR	tribute to t	he cause of death?	
ds,	The law requires that the death certifica sie hes been signed by the ettending ph page 2 should be detached for use as th		Takin salah sigilin salah sala	tilbuting to double but	11011030	ung in the u	idenying cat	use give	TIMIT CALL.			Yes 2			pably 4- Unknow	√n
Ö	w require	ete									24a. Was	. 20	24h	Ware auto	ansy findings availab	
Vital Records,	he la e hes age 2	Completed									auto	opsy ormed?		prior to co death?	psy findings availab impletion of cause of	1
tal	en: T	Be Co	25. Was case referred to medical						26 Place	of Death /	1□ Yes Check only	2€€N	0	1 ☐ Yes	2□ No	
$\geq$	ysici is cer direc	TO B	examiner? 1 ☐ Yes 2 ⊠No	lospital: 1 Sinpatient	t 2 🗆 E	ER/Outpatien	t 3 DOA	Othe	-		e 5□Res		6 □Oth	ner (Specii	(y)	
0	ng Pt	:uo	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	286	c. Injury Work	at ?	28	d. Describe	how inju	iry occur	red		
sio	tendi leath. tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be				М		'es 2□N							
Division of	or Attendent efter deatl Director: I in by the	Certification;	4 Homicide determined	28e. Place of Injury building, etc.	y - At hor (Specify)	me, farm, stre )	eet, factory,	office		28	City or To	(Street a	nd Numl re)	ber or Rura	al Route Number,	
_	spital		29a. Certifier to Certifying Physics	sician: To the best of	my know	viedge, death	occurred at	t the tim	e, date and	d place, an	d due to the	cause(	s) and ma	anner as s	tated.	
	To the Hospital or Attending Physician: The law within 24 bours effer death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check only 2 Medical Examination)	ner: On the basis of e and manner state	examınatı	on and/or inv	estigation, in	n my op	inion, deat	h occurred	at the time.	. date ar	d place.	and due t	o the cause(s)	
	within com	Σ	29b. Signature and title of certifier	0			29c.	License	number			29d. D	ate signe	d (Month.	Day, Year)	
	8		Mentin					600	874			3	122	106	*	
7	165		30. Name and address of person who co	impleted cause of dea	ath (Item	23a) (Type,			^				1	1		Ī
	Sta	ta	Ataa Ahmad, ( 31. Date filed (Months Gay, Year) 200	1.0. 625	's Signati	ent /	Tyenu	<u>le</u>	Cun	ber	land	11/	ary	land	21502	
	Registr		MAR Z 1 ZU	UD OU	tir ha	1	22421	7								

Amended #7, nls, 03/29/06, Allegany Co. 1 - For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mental Hygiene

State	OT	maryland /	Department	of	Health and	
			Certificate	01	f Death	

5 1	0	0	1
1 1	/	. 3	1.5

Physician	
/Medical	Ļ
Examiner	

Reg. No.

Funeral Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylend Depertment of Health and Mental Hyglene. Importent: if Item 27 is marked other then "netural", or Items 23a or 28a-f show any injury or other treumatic event, the Medical Exerciter must be netified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit To the Hospitel or Attending Physician: The law requires that the death certificate be executed 3 nas

n	THELMA JUANITA CROSS					2. Date of Deat Month MARCH	Day 25,	2006	3. Time of Death 1:37 P M		
ıl	4a. Facility Name (If not institution, give street and number)	4h	. City, Town, or	Location		MARCH	1	ounty of Death	<del></del>		
	CUMBERLAND NURSING HOME		CUMBER	RLANI	)			ALLEGA	NY		
	5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Mc	Under 1 Year onths Days	If Under:	Min	8. Date of Birth (Month, Day,	oate of Birth Month, Day, Year) C. 8,1912  9. Birthplace (State Country) WEST VIRG				
	236-14-0378	15.				DEC. 8,	1912	WEST	' VIRGINIA		
	10a. State 10b. County 10c. City, Town of	or Location	on						10d. Inside City Limits		
202	WV MINERAL RIDGE	ELEY							1 □Yes 2X No		
ē	10e. Street and Number	1	10f. Zip Code 10g. Citizen of What Country?								
Funeral Director	161 MAIN STREET		26753	3		U.S	5 . A .				
	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 No	13. Was	Decedent of His, specify Cubar	spanic Orig	jin? (Spe	cify Yes or No-	14.	Race - Ameri Black, White			
D L	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X☐ No		Yes 21∑ No	Specify:		. ,	Sc	necify:			
ם פ		\				1		. W.	HITE		
Jete	(Specify only highest grade completed) ((	Give kind life. DO N	s Usual Occupa ' <i>of work done d</i> VOT use retired)	ition <i>uring most</i>	of working	9	6b. Kind	of Business/Ir	ndustry		
Completed	College (1-4015+)		MAKER				НС	OME			
2	17. Father's Name (First, Middle, Last)			18. Mothe	r's Name	(First, Middle, N					
0	GEORGE B. LANG			RUS	SSIE	$\mathtt{TAYL}$	OR				
-	19a. Informant's Name/Relationship (Type, Print) 19b. N	Mailing Ad	ddress (Street a	nd Numbe	r or Rural	Route Number,	City or To	own, State, Zij	o Code)		
						LLIAMSPO			.795		
	20a. Method of Disposition 20b. Place of D	Disposition	n (Name of ry or other place	1	Da	ate 2	0c. Locat	tion - City or T	own, State		
-	1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  1 ☐ Donation 5 X Other (Specify) Fint animment MT • STAT			- 1	)3/29	/2006	EL	KINS, Y	WV		
1	21. Signature of Funeral Service Licentee					HOME, P	Δ				
	years fl. texcherca	2	02 GREE	NE S	'REE'I	CUMBE	RLAN	D, MD	21502		
	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.								Approximate Interval Between		
	Immediate Cause (Final disease or condition and Cere Dru Vas Cere Dru	. 00	· As	-:-0	1-	_			Onset and Death		
	resulting in death)  Due to (or as a consequence of)		1,0						wacays.		
	Sequentially list conditions b.										
2	Sequentially list conditions, if any, leading to immediate naise. Finter Interthing Triping Cause (Disease or injury	):						12			
	that initiated events										
	Due to (or as a consequence of)	):									
att/medical	d										
MIG	IF FEMALE: 23c. If yes, outcome of pregnancy						20.4	5-1			
a	in the past 12 months?		opic pregnancy per (specify)				230	. Date of deliv- Month	ery Day Year		
33	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	0 🗀 0 (1)	ioi (specify)								
7	Part II. Other significant conditions contributing to death but not resulting in the	he underh	ying cause give	n in Part I.		23e. Did toba	acco use	contribute to t	he cause of death?		
2	Coronary Artery Disease					1 ☐ Yes	2 □ N	lo 3 ☐ Prot	pably 4 Dnknown		
100	4					24a. Was an	2	4b. Were auto	ppsy findings available		
5						autopsy	ed?	death?	opsy findings available impletion of cause of		
	25. Was case referred to medical			26. Place	of Death	1 ☐ Yes 2, (Check only one	No	1 🗆 Yes	2 No		
2	examiner?  1 Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpa	atient 3	DOA Cthe			e 5 Resider		Other (Specif	(v)		
	27. Manner of Death 28a. Date of Injury 28b. Tim	ne of	28c. Injury Work			3d. Describe how			,,		
	2 Accident investigation	A.		es 2 🗆 N	lo						
	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)	, street, f	actory, office		21	Bf. Location (Stre	et and N	umber or Rura	al Route Number,		
5	Danaing, etc. (Oppolity)				Ŋ	, 5, 1,0411,	J. (10)				
anicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, day and manner stated. 2 Madical Examiner: On the basis of examination and/o and manner stated.	death occ or investig	urred at the time	e, date and inion, deat	place, ar	nd due to the car d at the time, da	use(s) and te and pla	d manner as s	tated. o the cause(s)		
Ď.	29b. Signature and the of certifier 1		29c. License number 29d. Date signed (Month, Day, Year)						Day, Year)		
	- Thousans		Door		7			-	, 2006		
-	30. Name and address of person who completed cause of death (Item 23a) (Ty	vne Dries		,, 43		,,,	(ave	4 2)	, 200 6		
1	Sunt Bunta, MD -625 Kent 1	A C	_	Los	Inn	d, mr	, (	1/502			
7	31. Date filed (Month, Day, Year) 32 Registrar's Signature	144	· ull	NIK	10016	0/ 11/	/ 0	1002			
	MAR 2 9 2006	Correspon	2								

State Registrar

Physician //Medical Examiner  1. Decedent's Name (First, Middle, Last)  STEPHEN CHARLES CASTLE  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location  EDEDED LOW MEMODIAL HOSDITAL  EDEDED LOW	2. Date of De Month MARCH	Day Year 25 2006	3. Time of Death	
/Medical Examiner  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location		25 2006		
Examiner  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location		MARCH 25 2006 6:53  4c. County of Death		
	on of Death			
FREDERICK MEMORIAL HOSPITAL FREDERICK  5 Social Security Number 6 Sex 7 And (In vrs. last birthday) If Under 1 Year   If Under	ler 24 Hrs. 8 Date of Bin	FREDERIC		
Funeral Director 5. Social Security Number 108–58–3568 6. Sex 1 Months Days Hours	s Min. 8. Date of Bin (Month, Da Feb. 3	, 1965 New	pplace (State or Foreign Intro) York	
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits	
Maryland Frederick Frederick			1√2 Yes 2 No	
That y Latitut , Trederick Trederick 10f. Zip Code		10g. Citizen of What Cou	untry?	
574 Eishenhour Drive 21703		U.S.A	-	
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic C If Yes, specify Cuban, Mexic	Origin? (Specify Yes or No	14. Race - Amer		
10a. State   10b. County   10c. City, Town or Location			e, etc.	
Specific Completed   Specifi	ny:	Specify: W	hite	
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during modifie. DO NOT use retired)  16b. Decedent's Usual Occupation (Give kind of work done during modifie. DO NOT use retired)  Project Manager	nost of working	16b. Kind of Business/I	ndustry	
Elementary/Secondary (0-12)  College (1-4or 5+)  4  Project Manager	r	Building B	usiness	
N POLITICAL TO THE TENER OF THE	other's Name (First, Middle	1		
The state of the s	y Lou Jolley			
That is not a series of the se	mber or Rural Route Numb	per, City or Town, State, Z	lip Code)	
Charles E. Castle/Father 100 Burgess Hill V				
20b. Place of Disposition (Name of cemetary, crematory or other place)	Date	20c. Location - City or		
1 Aburial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  Resthaven Mem. Gardet	ns 3/29/06	Frederick,	Maryland	
10a. State   10b. County   10c. City, Town or Location   10c. Ci				
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a			Approximate Interval Between	
shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  FNO STAGE RENAL DISEATE Due to (or as a consequence of):	KE		Onset and Death	
Sequentially list conditions, if any, bading to infinite devents cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):				
The past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 1 Live birth 2 Fetal death 1 Live birth 2 Fetal death 2 Control of pregnancy 1 Live birth 2 Fetal death 2 Control of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 5 Other (specify)		23d. Date of del Month	ivery Day Year	
Y S S S S S S S S S S S S S S S S S S S		tobacco use contribute to Yes 2 □ No 3 □ Pri	,	
Conditions and the state of the	24a. Was auto perti 1 \( \triangle Yes	opsy prior to o	itopsy findings available completion of cause of 2 \( \square\$\) No	
25. Was case referred to medical examiner?  1   Yes   2   No   Hospital:	lace of Death (Check only	one)		
The second secon	Nursing Home 5 Res		cify)	
27. Manner of Death 28a. Date of Injury at Work?  1 Matural 5 Pending (Month, Day Year)  28b. Time of Injury at Work?		how injury occurred		
So the second of		(Street and Number or Ru	iral Route Number	
27. Manner of Death  1		own, State)	nai noble Number,	
29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date (Check only (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, d	e and place, and due to the death occurred at the time	e cause(s) and manner as e, date and place, and due	s stated. e to the cause(s)	
To see the second secon		29d. Date signed (Mont	h, Day, Year)	
o € o 6 ≥ 29b. Signature and title of certifier 29c. License number	11116	2/25	2006	
E E 290. Signature and title of certifier  Kane h Hearn M D39L	144	5   25	_	
290. Signature and title of certifier  Carue h Heart MD 63 Thomas Johnson Drive, Free  Raren Hundemer, MD 63 Thomas Johnson Drive, Free				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2006 Clisham 20 mus /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
Feb. 7, 1928 **Funeral** Hours 1 M 2 XF 140-20-4497 Director 78 Yrs. Usual Residence of Decedent death with the Manyland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21742 19800 Tranquility Circle #115 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No δ 3 Widowed 4 Divorced "naturei", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: if Item 27 ie marked other it any injury or other treumatic event, Ita once. 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stella McCann James Patrick McCaffrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2700 Meadowridge Ct., Myersville, MD 21773 Kathyrn McClung/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/26/2006 Frederick, Maryland Frederick Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licentee 22. Name and Address of Facility Stauffer Funeral Home, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part1. Enter the / is -a shock, or hear ail y or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nterval Between List only one Onset and Death CEREBROVASCULAS Immediate Cause (Final disease or condition resulting in death) Physician Down /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (of as a consequence of): attending physicien and for use as the burial-transif or Attending Physician: The law requires thet the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) ete has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 3 ☐ Probably 4 ☑ Onknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy 2/ No 1 Yes 2 19 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Dinpatient Other: 1 ☐ Yes 2 PNo Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 06 30. Name and address of person who completed cause of death (Item/23a) (Type, Print) ARAN. 31. Date filed (Month, Day, Year) MAR 2 State 8 2006

DHMH 17 Rev 1/2001

Registrar

		•	1 - For State Registrar <b>Amend Item</b>	State of Marylan						giene Reg. No.	006	11237	
	Dhuniais		1. Decedent's Name (First, Middle, Last)	12 14 11 00	20 070	2100	<b>JII</b>		2. Date of De Month 3	ath Day	B		
	Physicia /Medic			DOUGLAS		CAR			3			9 733 7 "	
3	Examin	er	4a. Facility Name (If not institution, give s	treet and number)	- /	4b. City.	Town, or	Location of Death		40.0	County of Deal	n O de a	
	-		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Under	2// 1 Year	SDU/ Y If Under 24 Hrs.	8. Date of Bir	th	N/CON 9. Birt	hplace (State or Foreign	
	Funeral Director			M 2□F 55	Yrs.	Months	Days	Hours Min.	Sept. 7	195	0  Mic	n <b>i</b> gan	
	p .		Usual Residence of Decedent	100 0	y, Town or Lo	- antico						10d. Inside City Limits	
	ehov	5	10a. State 10b. County			Joanon						1 A Yes 2 No	
	the M	ect	Michigan   Wayne	De.	troit	10f. Zir	Code	_		10g. Citiz	en of What Co	puntry?	
	3a or	<u></u>	3762 Concord			482	07			Ţ	JSA	·	
	death	Funeral Director		2. Was Decedent Ever in U Armed Forces?		Was Dece	dent of His	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No	)- 1·	4. Race - Ame Black, Whit		
9	hours after death with the Maryland ture!; or fleme 23s or 28s-f show at Examiner must be notified at	y Fu	1 Never Married 2 Married	If Yes, Give 10	69-	1 Yes		Specify:			Specify:		
Ş	hours ture?	ed by	3 ☐ Widowed 4 ☐ Divorced			dent's Usu	al Occupa	tion		16b. Kin	d of Business	Black	
<u>.</u>	s filed within 72 h I Hygiene. other then "nati	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give	kind of wo	rk done di	uring most of work	king	100	uct As		
212	d with giene er the	mo:	12th	College (1-401, 3+)	labore	er/tec							
Maryland 21215-0036	be file Ital Hy Id oth event	Be	17. Father's Name (First, Middle, Last) Harold	Carte	er, Sr.			18. Mother's Nam Evelvn	ne (First, Middle	, Maiden S	Sumame) All	en	
<u> </u>	hould d Mer marke	은	19a. Informant's Name/Relationship (Typ			ing Addres	s (Street a	nd Number or Ru	ral Route Numb	er, City or			
<u>B</u>	and 2 s lith an 27 ie i		Ramona Combs-Cart					- Detroit					
ē,	of Heal		20a. Method of Disposition	1 ,	Place of Dispo	osition (Na	me of other place	9)	Date	20c. Loc	ation - City or	Town, State	
Ē	Peges nent of ant: If it ury or o		1 ☐Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	Det	troit M	emor	ial Pa	erk 04/01	/2006	Warre	en, Mic	higan	
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Deperment of Health and Mental Hygiene. Deperment of Health and Mental Hygiene. Important: If Ifem 27 is marked other than "naturel, or iteme 23a or 28a-f show any Injury or other treumatic event, the Medical Examiner must be notified at once.		21. Signature of Juneral Service Licente	. Jolley				s of Facility 12 EMORIAL			ad - S	alisbury, M1) 21801	
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused the deal	th. Do not en	ter the mo	de of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death	
).	Physician		Immediate Cause (Final disease or condition	pricono	Nin							Iwic	
	/Medical Examiner		resulting in death)	Due to (or as a consec		. 11		r 1					
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consec		21600	Vr7 1	ntech					
	outed Id ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
Ö,	cate be executed physicien and the burial-transit	EX	resulting in death) Last	Due to (or as a consec	quence of):								
8760,	icate b physic the b	dlcal	0	l									
9 X	certifi nding use as	√Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn						2	3d. Date of de	livery	
. Box	that the death certifit ed by the attending p detached for use as	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at lime of a 9 ☐ Unknown		□Ectopic p □ Other (s					Month	Day Year	
<u>о</u> .	at the 1 by th etache	Phys	9 Unknown					D. A.L	220 Did	tobooon	no contributo t	a the enuse of death?	
S,	The law requires that the death certificate be executed ate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit	l by	Part II. Other significant conditions con	ntributing to death but not res	suiting in the t	underlying	cause give	en in Part I.	1	Yes 2		o the cause of death? robably 4 🗀 Unknown	
Sor	w requires t been signe should be	letec	Sand						24a. Was	an	24b. Were a	ulopsy findings available	
Re	he lav e hes age 2	Completed	D. A.	( ) -					auto		prior to death?	completion of cause of	
Vital Records,	an: T tificet tor. pë	40	25. Was case referred to medical	Fall				26. Place of Dea			10.10	2 2 140	
	hysici nis ce I direc	To B	examiner? 1  Yes  No	lospital: 1 Impatient 2	] EP/Outpatie	ent 3 D	OA Othe	er: 4 🗌 Nursing H	ome 5□Res			ecify)	
Division of	Attending Physician: It death. Sector: After this certific by the funeral director.		27. Mann of Death 1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury Work	<b>c</b> ?	28d. Describe	how injury	occurred		
Sign	ttend death ctor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	nome, farm, st	M treet facto		Yes 2 □No	28f. Location	(Street and	d Number or F	Pural Route Number,	
<u>≥</u>	after after Direct	Certification:	4 Homicide determined	building, etc. (Speci			, ac		City or To	wn, State)	)		
	To the Hospital or Attending Physician: The Is within 24 horsus after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page?	edical C	29a. Certifier 1 Certifying Physical Check only 2 Medical Examinates	sicien: To the best of my kn ner: On the basis of examin- and manner stated.	owledge, dea ation and/or is	ith occurred nvestigatio	at the tim	ne, date and place pinion, death occu	, and due to the irred at the time	cause(s) , date and	and manner a place, and du	s stated. e to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of gertifier			25	c. License	e number		29d. Date	e signed (Mor	th, Day, Year)	
	100		Plat				H00.	56197		3/2	24/06		
	12		30. Name and address of person who co	empleted cause of death (Ite	_	, PrinI)	1	10	1 1	1	0112		
	10		31. Date filed (Month, Day, Year)	32. Redistrar's Sign	218 ature	New	ton!	7+ 75	MINS	M	2189	<u>y</u>	
	Sta Registi			006	le de	1.							

Description State   First, Morans, Lead)   Elevation of Value   First, Morans and Principles   Elevation of Value   First, Morans and Principles   Elevation of Value   First, Morans and Principles   Elevation of Value   First, Morans and Principles   Elevation of Value   First, Morans and Principles   Elevation of Value   First, Morans and Principles   Elevation of Value   First, Morans and Principles   Elevation of Value   First, Morans and Principles   Elevation of Value   First, Morans and Principles   Elevation of Value   First, Morans and Principles   Elevation of Value   First, Morans and Principles   Elevation of Value   First, Morans and Principles   Elevation of Value   First, Morans and Principles   Elevation of Value   El		1	For State Registrar	State of Maryland / Depa	artment of Hertificate of E			ene 006	11238				
Eleanton Clouart Cassidy  Eleantines provided pr		-						Day Year	3. Time of Death				
Example of Section Number of According or Design (Control Control		Eleanor Clouart	Cassidy		İ			7:25 P					
HeartLand Nursing Home    HeartLand Nursing Home   Same		_	4a. Facility Name (If not institution, give s	treet and number)	4b. City, Town, or	Location of Death		4c. County of Death	1				
Control   Cont			Heartland Nursing	Home	Hyatts	sville		Prince Ge	orge's				
Description of Desc		•	_			Hours Min.	8. Date of Birth (Month, Day, Y July 21,	(ear) 9. Birth Con 1927 Mass	un <i>try</i> )				
Separation   Part   P	D	-		100 City Town or Le	neation				10d. Inside City Limi				
Ellementary/Scionatary (1-12)   College (1-tor 5-)   Agents (1-t	Aaryla f shov				Callon				1 <b>7</b> Yes 2 □ N				
Beautiful part   Beau	28a-	3	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Co	untry?				
Elementary/Secondary (0-12)   Callege (14-of 5)   Agent (14-of 5)	with on the	5		enue	2070	)6		IISA					
Elementary/Secondary (0-12)   College (1-to-15-)   Report (1-to-15	ns 23	5					city Yes or No-	14. Race - Amer					
Elementary/Secondary (0-12)   College (14-of 5+)   Agent   Real Estate	Itan Itan	5		1 ☐ Yes 2 TNo			Rican, etc.)						
Elementary/Secondary (0-12)   Callege (14-of 5)   Agent (14-of 5)	Irs af	5		If Yes, Give	1 ☐ Yes 2 🔯 No	Specify:		Specify: W	hite				
Elementary/Secondary (0.12)   College (14-or 54)   Agent   Real Estate	stura sulf	3			dent's Usual Occupa	ition	16	6b. Kind of Business/	Industry				
Metropolitan Crematory 3-30-06   Alexandria, VA   Alexandria   VA   Contain the Value of the Contain of the C	n "n	2		life.	kind of work done d DO NOT use retired)	uring most of workii )	ng						
Metropolitan Crematory 3-30-06   Alexandria, VA   Alexandria   VA   Contain the Value of the Contain of the C	iene iene iene	5	Elementary/Secondary (0-12)		Agent		F	Real Estat	e				
A	Hyg Hyg ant.	5	17. Father's Name (First, Middle, Last)		1195111	18. Mother's Name							
A	d be shall be contained of the shall be contained of the	ם ב	Leo Clouart			Jenny 1	Postma						
Superior   Superior	mari mati		19a. Informant's Name/Relationship (Ty										
Supervision   Supervision	d 2 s th an trau trau		, , ,		Greenwoo	od Lane La	anham, M	20706					
Supervision   Supervision	1 an Heal am 2 thar	1							Town, State				
22a_Part   Enter mediabase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.   Intreval Betwoen the death of the cause of the death of the cause of t	or o		1 Burial 2 McFermation 3 Hemoval from State   MoFerman 1 if the Comment and 2 20 00   7 I arranging 177										
23a. Part   Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.    Interval Betwoen the death   Do not enter the mode of dying, such as cardiac or respiratory arrest.	tmer tant dury	i		A A Metropor.	Lan Crenc	a correction	50-00 F	-	, VA				
23a Part Einer mediatases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.	ermil Pepar ny in ny in		21. Signature of Funeral Service License	of Knowton	2. Name and Addres 5512 NTω (	rain Hunz	ll Funera	al Home					
Consett and Discovery Consett and Discover	40 F & 0	1	Numara	300110101									
Immediate Cause (Final disease or condition dealing in dealin)   Due to (or as a consequence of):			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the death. Do not en ne cause on each line.	ter the mode of dying	g, such as cardiac d	r respiratory arres	it,	Interval Between Onset and Death				
Due to (or as a consequence of):    Due to (or as a consequence of):	hysician		Immediate Cause (Final disease or condition	BMY	12001B	S							
Sequentially list conditions, if any, leading to minediate cause. Enter Underlying that inflated work 1907 has been death   23c. If yes, outcome of pregnancy that inflated work 1907 has inflated work 1907 h	/Medical								10				
Due to (or as a consequence of):    Comparison of the control of t	xaminer		Conversion to the transfer of										
Due to (or as a consequence of):    Comparison of the control of t	e e	<u> </u>	if any, leading to immediate	Due to (or as a consequence of):									
FFEMALE:   23c. If yes, outcome of pregnancy   1   23c. If yes, outcome of pregnancy	ansi		that initiated events										
Second of the complete of th	an an an rial-tr	Ě	resulting in death) Last	Due to (or as a consequence of):									
Second of the complete of th	sicia sicia	<u>a</u>		1									
Second of the complete of th	p phy string the strin		_						-				
Second of the complete of th	nding use a	5			76.			23d. Date of del	ivery				
Composition of the complete	atte	5	in the past 12 months?					Month	Day Year				
The part of the pa	y the	2		9□ Unknown									
The property of the property o	that deta		Part II. Other significant conditions con	ntributing to death but not resulting in the	underlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?				
Section   Sect	8 5 5	3	AN	EMIA			1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Unknow				
autopsy performed?	required hould	200					240 1460 00	24h Wore at	toney findings availa				
25. Was case referred to medical examiner?	a law has t e 2 s	2					autopsy	prior to death?	completion of cause of				
25. Was case referred to medical examiner?	pag Pag	5							2 🗆 No				
Section   Sect	ortific ctor,	ע	avaminar?		24		(Check only one	)	-				
Natural   Succident   Succid	ysic ais ce dire	2		1 Inpatient 2 ENOutpatie	nt 3 DOA	4 mursing Ho			cify)				
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SOR(-SIKUMAR MUTATH 4203 QUEENSBURY RD. HYATTSVILLE, MD 205	ter th	É		28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. Injury Work	rat k?	28d. Describe hov	v injury occurred					
29a. Certifying Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only one)  29a. Certifying Physician: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SORI-SIKUMAR MUTATH 4203 QUEENSBURY RD. HYATTSVILLE, MD 205	ath.		Accident investigation		M 1□	Yes 2 □ No							
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SOR(-SIKUMAR MUTTATH 4203 QUEENSBURY RD. HYATTSVILLE, MD. 205	Affecto de by the by the by the best of th	=	dotominad	28e. Place of Injury - At home, farm, st	reet, factory, office				ıral Route Number,				
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SOR(-SIKUMAR MUTTATH 4203 QUEENSBURY RD. HYATTSVILLE, MD. 205	s after	5		ballaling, etc. (Specify)									
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  3/25/06  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SOR(-SHKUMAR MUTTATH 4203 QUEENSBURY RD. HYATTSVILLE, MD 205	nera / fille	0	29a. Certifier /1 Certifying Phy	sician: To the best of my knowledge, dea	th occurred at the tim	ne, date and place,	and due to the cau	use(s) and manner as	stated.				
298. Signature and title of certified  Pureseer MD DOOSEA90 3/25/06  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SOR(-SHKUMAR MUTTATH 4203 QUEENSBURY RD. HYATTSVILLE, MD 201	e Ho e Fu letely		(Check only one) V2 Medical Exami	ner: On the basis of examination and/or in and manner stated.	rvestigation, in my of	oinion, death occurr	ed at the time, dat	te and place, and due	to the cause(s)				
4 Grusser MD DOOSTAGO 3/25/06  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SOR(SHKUMAR MUTTATH 4203 QUEENSBURY RD. HYATTSVILLE, MD 201	m thir	M	29b. Signature and title of certifier		29c. License	number .	29	d. Date signed (Mont	h, Day, Year)				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SOR(-SAKUMAR MUTTATH 4203 QUEENSBURY RD. HYATTSVILLE, MD 20	1/2		Win.	10012 110	000	CRIGA		3/25/	06				
SORESHKUMAR MUTTATH 4203 QUEENSBURY RD. HYATTSVILLE, MD 20	110	1				200210		-1	1				
			Out reame and address of person who co			and har	HVATT	SHILE. Y	10 2070				
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature			SORESTAKOMIAK Day Yangi	1011A117 4xU3 (	XO CC NSIS	UKT KU.	MYRTH	JVICCE/ N	15 ×0 10				

			1 _ State	Department of Health and Meni Certificate of Death	2000 11000					
*			Registrar  1. Decedent's Name (First, Middle, Last)		Reg. No. 3. Time of Death					
	Physici		Leeanna Cameror		Month Pay Th 2006 6: 45A M					
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Howard (Owner General Hos)	4b. City, Town, or Location of Death ,	4c. County of Death  If Oward!					
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit 578-20-4235 1	Months Days Hours Min. (#	pate of Birth Month, Day, Year)  C. 14, 1913 Virginia					
	pur *		Usual Residence of Decedent  10a, State 10b, County 10c, City, Tow		10d. Inside City Limits					
	Maryla f sho	ō	Maryland Anne Arundel Seve		1  Yes 2 □ No					
	1 the 1	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?					
	h with	<u>_</u>	7911 Carriage Drive	21144	United States					
	ems ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar						
21215-0036	within 72 hours after death with the Maryland ane. than "naturel", or Items 23a or 28e-f show he Wadigal Evaluate for invitible at	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify: Black					
5-0	natu dical	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry					
121	within lene. then	mp	Elementary/Secondary (0-12) College (1-4or 5+)	Domestic Worker	Davidson					
	filed Hygie other		17. Father's Name (First, Middle, Last)		Private st, Middle, Maiden Sumame)					
lan	Mental   Merked o	To Be	Unknown	Unknow	wn					
Maryland	od 2 shall the and the street of the street			o. Mailing Address (Street and Number or Rural Roll 11 Carriage Drive; Seve:						
Baltimore,	0 0		1 ₺ Burial 2 □ Cremation 3 □ Removal from State Pone	of Disposition (Name of processing the processing of the processing the processin	20c. Location - City or Town, State					
Balti	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility 553	ope Funeral Homes 538 Marlboro Pike Forestville, MD. 20747					
			23a. Part1. Enter the cisease, or complications that caused the death. Do shock, or heart silver. List only one cause on each line.							
M	Physician		Immediate Cause (Final disease or condition	Sepus	Onset and Death					
1	/Medical Examiner		resulting in death)  Due to (or as a consequence	/1						
	LAGITITIES	١	Sequentially list conditions, b. Diva to (or as a consequence	preumonia						
	ted	Examiner	cause. Enter Underlying Cause (Disease or injury	Deminona.						
,	execunate and al-train	Exar	that initiated events c	o concerce						
8760,	cate be executed ohysician and the burial-transit	dicai	d							
9	ntificat ng phy as th	a a	To Secure							
.O. Box	The law requires that the death certificate be executed tte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/M	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery  Month Day Year					
<u>α</u>	equires that sen signed b ould be deta	by	Part II. Other significant conditions contributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes  No 3 ☐ Probably 4 ☐ Unknown					
I Records,		Completed			24a. Was an autopsy findings available prior to completion of cause of death?  □ Yes 2 No  24b. Were autopsy findings available prior to completion of cause of death?					
Vital	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death (Che	eck only one)					
of	Phys this al dii	2	1 Yes 2 No Hospital: Inpatient 2 FR/Oil 27. Manner of Death 28a. Date of Injury 28b.		5 Residence 6 Other (Specify)					
	ing After une	tlon	1 Natural 5 ☐ Pending (Month, Day Year)	Time of 28c. Injury at 28d. [ Injury Work?  M 1 ☐ Yes 2 ☐ No	Describe how injury occurred					
Division	or Attending after death. Director; After d in by the funer	Certification:	2	arm, street, factory, office 28f. L	ocation (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital or # within 24 hours after To the Funeral Dire completely filled in b	edical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge (Check only one) Medical Examiner: On the basis of examination are and manner stated.	e, death occurred at the time, date and place, and d d/or investigation, in my opinion, death occurred at	tue to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)					
	To the within To the	Me	29b. Signature and title of centrier	29c.,License number	29d. Date signed (Month, Day, Year)					
•			> solue mo	D50870	march-1814 2006					
2	(8)	4	30. Name and address of person who completed cause of death (Item 23a) SUZAN ALJOD SOOS JIGNAL	Typh Prins Clark	march-18th 2006 usulle MD 01029					
s,	∜ Sta Registr	-	31. Date filed (Month, Day, Year) MAR 2.7 2006 32. Registrar's Signature	Soul !						

			For State Registrar	State of Ma	aryland /		artment of F		d Mental Hy	giene Rag. Ño.	6	11240		
	Physici	_	1. Decedent's Name (First, Middle, Last	Annett	æ C.	Cri	vella		2. Date of De Month March	ath 23, <sup>Day</sup> 2006	_Year	3. Time of Death 6:14 P M		
)	/Medic Examir		4a. Facility Name (If not institution, give Montgomery Gene		ital		4b. City, Town, o	ney		4c. County Mont	of Death	ery		
^	Funeral Director		5. Social Security Number 6. Se 213–46–9293	x 7. Ag ] M 2 <b>⅓</b> F	e (In yrs. last 98	birthday) Yrs.	If Under 1 Year Months Days	Hours M	in. B. Date of Bir (Month, Da Feb 2,	1908	Coui	place (State or Foreign ntry) nsylvania		
	he Maryland 28a-f ehow culfred at	ctor	10a. State 10b. County  Maryland Anne Arn	ındel	10c. City, To	own or Lo		nnapoli	S			10d. Inside City Limits  Ty∏Yes 2 ☐ No		
	with th	i Director	10e. Street and Number 545 Choptank Cox	æ Court			10f. Zip Code	1401		10g. Citizen of V	Vhat Cou	•		
920	72 hours after death with the Maryland natural', or itema 23a or 28a-f ehow dical Examirat qual be natified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ ff Yes, Give Year or Dates:				lispanic Origin? an, Mexican, Pu	(Specify Yes or No lerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.  Specify: White				
21215-0036	within ane. than	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12th			3a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired Homemake	during most of ( d)	working		16b. Kind of Business/Industry  Private			
	be filed stal Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last) Michael Erdesky						<sub>Name (First, Middle</sub> usan Kaza		e)			
Mary	ts of Li		19a. Informant's Name/Relationship (T) Rosemarie Connors						Rural Route Numb Ourt, Ann					
Baltimore,	0 0 = =		20a. Method of Disposition  Burial 2 Cremation 3 4 Donation 5 Other (Specify,	Removal from State	20b. Place ceme	of Dispo	osition (Name of matory or other place ret Cemete	ce)	Date 25/2006	20c. Location - Washing	City or To	own, State		
Baltin	permit. Pag Department Important: any Injury o		21. Signature of Funeral Service Licens			2:	2. Name and Addre	ss of Facility		endon/Hale Funeral Home ad, Lanham MD 20706				
8760,	Physician /Medical Examiner   Medical Examiner   Physician and   Physician and   Physician and   Physician   Physi	icai Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list candidate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as  Due to (or as	ne. Seps a consequence	ce of):	y trac		He ( h) c			Approximate Interval Between Onset and Death		
P.O. Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopris? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal dea		□Ectopic pregnancy □ Other (specify)	/		23d. Dat Mo	e of deliv	ery Day Year		
	quires that n signed by ald be deta	by	Part II, Other significant conditions co	ntributing to death b		g in the u	inderlying cause giv	en in Part I.	23e. Did 1	/	-	he cause of death?		
Records,	The law require ate has been sip page 2 should b	Completed	Dementin						24a. Was auto perfo	psy ormed?	prior to co death?	opsy findings available ompletion of cause of		
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospitaf:			Ott		Death (Check only					
of	or Attending Physician: utter death. Director: After this certification by the funeral director, in	ation: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da	ıry 28	Outpatie b. Time o Injury	f 28c. Injur Wor		g Home 5 Resi	dence 6 Oth		fy)		
Division	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined		ury - At home c. (Specify)	, farm, st	reet, factory, office			Street and Numb wn, State)	er or Rur	al Route Number,		
	Hospital 24 hours a Funeral I etely filled	Medical		rsician: To the best iner: On the basis of and manner st	f examination									
	within 2 To the	Me	29b. Signature and title of certifier	eu z	v		29c. Licens	se number 854		29d. Date signed	Month.	Day, Year)		
R	(U)		30. Name and address of person who de 19)/0   Privide	Phill	ip C	VIV	Print) Olv	res, r	10 H	eather	Lor	ok enzo, ilb		
	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 7 2006	Registr	rar's Signature	La	est.							

			For State Aegistrar	State of Mar			nt of Health and te of Death	d Me		iene eg. No. 2 (	106	11241
87	B		1. Decedent's Name (First, Middle, La	st)				2.	Date of Deat Month	th Day	Year	3. Time of Death
)	Physici /Medio Examin	cal	Agnes Elizabet  4a. Facility Name (If not institution, giv			4b. Cit	, Town, or Location of D		March	20, 2 4c. Count	006 y of Death	3:30 A. <sup>M</sup>
***	Funeral Director		235 Harry S. Tr 5. Social Security Number 6. S 578–20–5701		# 14 In yrs. last birthday Yrs.		argo er 1 Year   If Under 24   s Days Hours N	Ain.	Date of Birth (Month, Day 11/26/2	Year)	9. Birth	place (State or Foreign intry)
	pu .		Usual Residence of Decedent  10a. State 10b. County		Oc. City, Town or L	ocation						10d. Inside City Limits
	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-f ehow ta Madigal Examilier Lassi Le notified at	ū			•							1X Yes 2 □ No
	28a-1	Director	Md. P.	.G.	Larg		ip Code		1	0g. Citizen of	What Cou	untry?
	3a or	١	235 Harry S. Tr	ruman Drive	# 14		20774			II.	S.A.	
	death ms 2	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?		. Was Dec	edent of Hispanic Origin ecify Cuban, Mexican, P	? (Specif	ty Yes or No-	14. Ra		ican Indian,
9	or Ite	F	1 Never Married 2 Married	1 ☐ Yes 2 🔯 No If Yes, Give			21 No Specify:		Julii, 515.7	Spec		3lack
21215-0036	ural',	d by	3 ¼Widowed 4 ☐ Divorced	Year or Dates:	100							
15-	"nati	Completed	15. Decedent's E (Specify only highest gr.		16a. Dec (Giv life.	edent's Us e kind of v DO NOT	ual Occupation rork done during most of use retired)	working		16b. Kind of	dusiness/i	naustry
12	withii iene. than	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	Co		,			Culir	ary	
9	Hygother ent,	BeC	17. Father's Name (First, Middle, Last	)			18. Mother's	Name (/	First, Middle,	Maiden Suma	me)	
<u>a</u>	Ald be Aenta rked tic ev	To B	James Spriggs				Agn	es C	Green			
Maryland	permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or any injury or other traumatic event, tra Madical Exampace.		19a. Informant's Name/Relationship	•	1		ss (Street and Number o					
Σ.	and seath m 27		Deborah Cumbo/Da	ughter			y S. Truman					
Baltimore,	M iter		20a. Method of Disposition  1X Burial 2 Cremation 3	Removal from State	20b. Place of Dist cemetery, cri	ematory of	other place)	Dat	е	20c. Location	- City or I	own, State
Ë	ment tant:		4 □ Donation 5 □ Other (Speci	7	Harmony	Mem.	Park 3	/24/	<b>'</b> 06 _	Landov	er,	Jaryland
Bai	Depar Depar Impor Impor		21. Signature of Funeral Service Lice	nsee A A	7.	H S	Washington & Burroughs	So	ns Co.	Inc.	rton	D C 20019
6/1	40200		23a. Part1. Enter the disease, or con	unlications that caused the							J COII,	Approximate
6.4			shock, or heart failure. List only Immediate Cause (Final	one cause on each line	•							Interval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death)		cic Cance:	r of	Stomach				-	
- 22	Examiner					f the	Pone					
	* %	Je.	Sequentially list conditions, if any, leading to immediate	b. Pagets I Due to (or as a	consequence of):	T +116	DOME					
	te be executed ysician and te burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		f Chronic	c Dis	ease					
o,	e exe	E	resulting in death) Last	Due to (or as a	consequence of):							
ന		dical	•	d								
9 ×	death certifica e attending ph d for use as tl	Physician/Med	IF FEMALE:	23c. If yes, outcome of	pregnancy					004.5	ato of doli	
Вох	atten for us	ian	23b. Was decedent pregnant in the past 12 months?	1□Live birth 2	Fetal death 3	☐Ectopic	pregnancy specify)				ate of deli Ionth	Day Year
o.	the de y the iched	ysic	1 Yes 2 No	9□ Unknown								
<u>α</u>	wrequires that the de been signed by the should be detached	by Pt	Part II. Other significant conditions	contributing to death but	not resulting in the	underlying	cause given in Part I.		23e. Did to	bacco use co	ntribute to	the cause of death?
Records,	requires een sign oould be		•						1 🗆 Y	es 2 No	3 🗆 Pro	obably 4 Unknown
00	s bee	Completed							24a. Was a	an 24b	. Were au	topsy findings available
R	The lav	E O						_	perfor		death?	
ita	ician: Th certificate rector, pag	BeC	25. Was case referred to medical examiner?				26. Place of	Death (	Check only o			
\ \	Physician: r this certific ral director,	To	1 Yes 2 No	Hospital: 1   Inpatien	<del></del>							cify)
D C	nding Pl th. : After tl e funera	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	1	28c. Injury at Work?	28	d. Describe h	ow injury occ	urred	
Division of Vital	tendi leath. tor: A	Certification:	2 Accident investigated 3 Suicide 6 Could not		A h 4	M	1 Yes 2 No	20	t Location (S	troot and Nur	abor or Pu	ral Route Number,
ΣĬ	or At iffer of Direct in by	rtiffi	4 Homicide determined		y - At home, farm, : (Specify)	street, ract	ory, οπice	20	City or Tow		ID <del>O</del> I OI ND	ras noble sybilibes,
	the Hospital or Attenthin 24 hours after death the Funeral Director:	edical Co		hysician: To the best of miner: On the basis of and manner state	examination and/or							
	To the Horwithin 24 h To the Fur	₹ E	29b. Signature and title of certifier	0			29c. License number		;	29d. Date sign	ned (Monti	n, Day, Year)
	- > - 0		▶ & d	3			D48152			3/2	0/20	200
R			30. Name and address of person who	completed gause of de			cantile Lan	e, I	argo.	Marvla	nd 20	)774
	Sta	ate	31. Date filed (Month, Day, Year)  MAR 2 4 200	32. Registrar		- P						

			1 - For State Registrar	State of	Marylan		artmen rtificate			and M	lental Hyg	iene	)	11242
*	Physici	- 31	CHIE CHEW Mar 22 2006										Year	3. Time of Death 6:15 A M
	/Medic Examir	_	4a. Facility Name (If not institut	ion, give street and numb			4b. City,		Location o		4c. County of Dea			vert .
N. S.	Funeral Director		5. Social Security Number <b>215-36-5495</b>		Age (In yrs. 87	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Sep 9, 1	Year) 1918	Cou	place (State or Foreign intry) <b>Maryland</b>
	Maryland	tor	Usual Residence of Decedent  10a. State 10b. Cour  MD	Calvert	10c. Cit	y, Town or Lo	cation	Pri	nce Fre	ederick	(			10d. Inside City Limits 1 ☐ Yes 2X No
	3e or 28s	i Direc	10e. Street and Number 1602 Mason Court				10f. Zip	Code	20678	В	11	0g. Citizen of W	hat Cou	
036	be filed within 72 hours after death with the Maryland ital hygiene. Id other than "naturel", or Iteme 23a or 28a-f show event, the Madical Examinar must be invitited at	by Funeral Director	11. Marital Status 1 Never Married 2 M Widowed 4 Divorce	If Vas Giva	es? <b>X</b> No		Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto	ecify Yes or No- Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.  Specify: Black		
Maryland 21215-0036		Completed		ent's Education hest grade completed) ) College (1-4	or 5+)		dent's Usua kind of woi DO NDT us	rk done d se retired	furing mos.	t of worki	ng	Someor		e's Home
land	should be filed v nd Mental Hygie i marked other t imatic event, L.	To Be C	17. Father's Name (First, Middle	Samuel H	urley				18. Mothe	er's Name	e (First, Middle, M Ella	Maiden Sumam Johnson	9)	
Mary	nd 2 shoulth and N 27 is main		19a. Informant's Name/Relatio				-	-			Al Route Number, MD 20678	City or Town,	State, Zi	p Code)
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked ony Injury or other treumatic evanges.		20a. Method of Disposition  ★□ Burial 2 □ Crematio 4 □ Donation 5 □ Other		ate	lace of Dispo emetery, crer outhern Me	natory or o	ther plac			28/06	20c. Location -	City or T unkirk	
Balt	permit. Departr Imports eny Inji		21. Signature of Funeral Service  **Dladys**	a Sewel	e	22	Name an Sew 145				nd Prince Fr	ederick, M	D 206	578
100	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a	ch line.	MOI uence of):		e of dying	g, such as	cardiac c	or respiratory arre	est,		Approximate Interval Between Onset and Death
68760,	ficate be executed physician and is the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseq	uence of):								
P.O. Box	that the death certifical today the attending phy detached for use as the	Physician/Med	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		h 2∏Feta ntattime of d	Ideath 3	Ectopic pr Other (sp					23d. Date Mor		very Day Year
	The law requires that the to has been signed by the bage 2 should be detache	þ	Part II. Other significant cond	h h	th but not resi	Δ.	1			use	23e. Did tob	/		the cause of death?
al Records,		Completed	End-St Anaem	isa,	eme:	ntic	( 1				24a. Was an autops perform	y ned?	Vere aut rior to co leath?	opsy findings available ompletion of cause of
f Vital	lysicien: Th	To Be	25. Was case referred to medi examiner?  1  Yes 2  No	Hospital	patient 2	ER/Outpatier	nt 3 DC	Othe	200		n <i>(Check only on</i> me 5 ☐ Reside		er (Spec	ufy)
Division of														
Divis	F 9 F C	Certification:	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	mined 286 Place 0	f Injury - At ho , etc. <i>(Specif</i> y	ome, farm, str	eet, factory	, office			28f. Location (St. City or Town	reet and Numbi n, State)	er or Rui	ral Route Number,
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	edical	29a. Certifier 1 Certification (Check only one)	ying Physician: To the b al Examiner: On the bas and manne	is of examina	wledge, death tion and/or in	h occurred vestigation,	at the tim , in my of	e, date an pinion, dea	d place, th occurr	and due to the ca ed at the time, da	ause(s) and ma ate and place, a	nner as ind due	stated. to the cause(s)
	To t To t	M	29b. Signature and title of certification	fier C.	for	ana	290		065	3	25	9d. Date signed $3-2$		, Day, Year) 2006
<u> </u>	3		30. Name and address of person	Deale	chu	Tels to	Print) (	34 f	AN acl.	· C	Seale	RUMS	. 2	0751.
200	Sta Registr	_	31. Date filed (Month, Day, Yea	R 2 4 2006	gistrat's Signa	ture #	Le	NO.						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 19<sup>Day</sup>2006<sup>Year</sup> **Physician** March 6:45 RM William Albert Conner, II /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Calvert Calvert Memorial Hospital Prince Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth June 25 1945 6. Sex Birthplace (State or Foreign
 Country) **Funeral** 1 JM 2 □ F Months Days Hours 219-48-2001 60 Director Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State ral', or Itams 23a or 28a-t show Exerciter must be notified at Maryland Calvert Prince Frederick 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3125 Adelina Road 20678 United States filed within 72 hours after death Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ★ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specifiwhite Completed by 3 ☐ Widowed 4 ☐ Divorced "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) treumetic evant, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene. 7 is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) agriculture/ PEPCO 12 farmer/ welder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phyllis Hope Buck William Albert Conner 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: It itam 27 is rr any injury or othar treum once. 3125 Adelina Rd. Prince Frederick MD 20678 Linda Kay Conner- wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Asbury Cemetery March 23 2006Barstow Maryland 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Rausch Funeral Home Browsch 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ingestive heart disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Ischemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of): Examiner that the death certificate be executed burial-transit Atrial Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 Yes 2 No Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 No 1 Yes 1 ☐ Yes 2 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Man or of Death Date of Injury (Month, Day Year) after death. 28b. Time of 28d. Describe how injury occurred Attending 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident in by the 3 🗌 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ō Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical within 2 To the To the 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier  $\omega_0$ 060390 30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print) PRINCE FREDERICK RO HOSPITAL 00 ADEEB JABER 32. Registra/s Signature 31. Date filed (Month, Day, Year) State 23 2006 Clores Registrar

				Please Type or Print in Black in		-	-	
				State of Maryland / Dep	ertificate of Death		ZIIIIh	11266
	(6)		q.	Registrar  1. Decedent's Name (First, Middle, Last)	erinicale of Dealif	2. Date of Death	g. No.	3. Time of Death
	J	Physici /Medio		GENEVIEVE GILARDI DUARTE		March		4:55PM
		Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
				Doctor's Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Lanham  If Under 1 Year If Under 24 Hrs.	O Date of Birth	Prince G	
	ì	Funeral Director		360-07-2344 1□ M 2X F 87 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, 1) Nov. 16,	(ear) (Co 1918 I11	nplace (State or Foreign untry) nois
		land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or I	.ocation			10d. Inside City Limits
)		Marylan -f ehow iled at	ō	Maryland Prince George's Glenn Da	a1e			1 XYes 2 No
12		vith the Maryla or 28e-f ehor be notified at	lrec	10e. Street and Number	10f. Zip Code	10	g. Citizen of Whal Co	untry?
UART		23a c	by Funeral Director	10030 Worrell Avenue	20769	τ	J.S.A.	
4		after deeth v or Items 23e miner must	ıner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Sp. II Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
7	36	s afte	Ž.	1 Never Married 2 Married 1 Yes 2 X No	1 ☐ Yes 2 🖾 No Specify:		Specify: Wh	ite
0	5-0036	within 72 hours after deeth with the Maryland ene. than "neturel", or Items 23e or 28e-1 ehow he Maridial Examinar must be notified at	ed b	16 Decedent's Education 16a Dec	edent's Usual Occupation	16	6b. Kind of Business/	
	215	nin 72 n "ne	plet	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	ing	55. 11.114 57 555115541	
0	212	73 75 6- 1-1	Completed		tistician		Federal G	overnment
	nd	be filed tat Hygie d other	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	aiden Sumame)	
3	yla	2 should be 1 and Mentail is marked of eumatic eve	To Be	Samuel John Gilardi		Craigmi		
ne vieve	Marylan	s 1 and 2 should be filed f Health and Mental Hyg item 27 is marked othe other treumatic event,	1 18		ling Address (Street and Number or Rura		,	
7		1 and 2 Health em 27 I		Marie Bowles Centa - Daughter 504  20a. Method of Disposition 20b. Place of Disp	Ethan Allen, Takon position (Name of ematory or other place)		Maryland 2 Oc. Location - City or	
5	o D	8,2 = 5		1 22-bullar / Cremation 3 Linemoval from State	l l			
C.	Baltimore,	i i o a ii			Heaven Cemetery 3/29 22. Name and Address of Facility Gas	ch's Fun	eral Home.	P.A.
0	ä	Depa Impo eny ii			739 Baltimore Ave.			
•	760,	Physician /Medical Examiner and parial-transit	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not ensplock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	ry farlure  Aleut			Approximate Interval Between Onset and Death
	Box 687	Attending Physician: The law requires that the death certificate be executed rideath. rideath. ector: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	in the past 12 mgmths?	□Ectopic pregnancy		23d. Date of deli	very Day Year
	0.	of the de by the a	hysic	9 ☐ Unknown	Other (specify)			
	Division of Vital Records, P.O.	w requires thets been signed to should be deta	ed by F	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute lo	the cause of death?  obably 4 Hunknown
	3eco	e law re has bee	Completed	Sinus Rundy Cardy Renal Insufficion	e'	24a. Was an autopsy performe	24b. Were au prior to death?	topsy lindings available completion of cause of
	a	ilcian: The li certificate ha rector, page 3	e Co	25. Was case referred to medical	,	1□ Yes 21	ZNo 1□Yes	2 No
	Ξ	ysician: is certific director,	To Be	examiner?  1 Yes 2 No  Hospital: 1 Impatient 2 ER/Outpatie	Others	Check only one	ce 6 Other (Spec	26.1
	on of	ding Phys h. After this funeral di	tlon: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident Investigation  28a. Date of Injury (Month, Day Year) Injury		28d. Describe how		my)
	Divisi	or Attendiater death. Director: A in by the fu	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury · Al home, farm, s building, etc. (Specify)	treet, factory, office	281. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number.
	_	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely lilled in by the fu	edical Co	29a. Certifier (Creek willy one)  12 Certifying Physician: To the best of my knowledge, deal can be summation and/or and manner stated.	ith occurred at the time, date and place, nvestigation, in my opinion, death occurr	and due to the cau red at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)
		o the	Mec	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Monti	n, Day, Year)
		->		Man 15 n	0 22/1/		3/47/0	6
()	2	(4)		30. Name and address person which completed cause of death (Item 23a) (Type Thomas Y. Ko, MD 8100 Good Luck Ro	/			
		Sta Registr	-	31. Date Illed (Month, Day, Year)  MAR 2 9 2006				
				111111111111111111111111111111111111111				

			For 1 _ State	State of Ma		/ Depa	artmen	t of H	ealth a		_		-	11215
		-	Registrar  1. Decedent's Name (First, Middle	(act)		Cer	tificate	OIL	Jeani		2. Date of Dea	Reg.'No.		3. Time of Death
	Physici	an		•							Month March	Day		6:55 a M
	/Medic Examin		JOHN WILLIS D  4a. Facility Name (If not institution,				4b. City,	Town, or	Location o	of Death	Haren	- T	County of Deat	
10 A	EXAMILI	(C)	Montgomery Ge		o 1			01ne					Montgom	
	Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. las	t birthday)	If Under Months		If Under	24 Hrs. Min.	8. Date of Birt (Month, Da	h		hplace (State or Foreign untry)
Š	Director		213-09-8148	1⊠M 2□F	86	Yrs.	WOTHING	Duys	110010		July 2	8, <u>1</u>	919 Ma	ryland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Fown or Lo	cation							10d. Inside City Limits
	Maryi feho	ō	Maryland Montg	omerv	G	aithe	rsbur	ď						1. Yes 2 □ No
	r 28e	Director	10e. Street and Number			410110	10f. Zip					10g. Citi	zen of What Co	untry?
	th with		18520 Cape J.	asmine Way				2087	9				U.S.A.	
	eme	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. \	Was Deced	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)		14. Race - Ame Black, White	
36	s afte	by F.	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☑ Divorced	ed 1 X Yes 2 No If Yes, Give Year or Dates: 1			1 ☐ Yes 2		Specify:				Specify:	
21215-0036	hour	ed b	15. Decedent				dent's Usua	l Occupa	ution			16b. Ki	nd of Business/	hite Industry
15	nin 72 n 'n	Completed	(Specify only highes. Elementary/Secondary (0-12)	r grade completed)  College (1-4or 5+		(Give	kind of wor DO NOT us	k done d	uring most	t of workii	ng			
212	d with	E O	12	College (1-401 34	,		Engi	neer				Te	lephone	Company
nd	be filed within 72 hours atter death with the Maryland tal tygene. d other than "netural", or Iteme 23a or 28e-f ehow event, the Medical Examinar must be notified at	Be (	17. Father's Name (First, Middle, L	•					18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)	
<u>   </u>	Meni Meni Meni Meni Meni Meni Meni Meni	2	Frank Joseph		_								Dermot	
Maryland	12 sh h and 7 is m		19a. Informant's Name/Relationsh  Ken Darnell -				•	`					r Town, State, 2	
e) -	1 and Healt am 2		20a. Method of Disposition	5011	20b. Plac	e of Dispo	sition (Nan	1e of		Way	. Gaith	erst 20c. Lo	cation - City or	ryland 20879 Town, State
<u>o</u>	Pages nent of I ant: If Itu		1 ⊠ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp				natory`or o			00/0	T (0000			
Baltimore,	프로필급		21. Signature Puneral/Service		rort	Linco	In Cer	netery d Addres	s of Facilit	03/2. y Ga	5/2006 sch's E	uner	al Home	Maryland
ñ	Dep Imp		Hali intella	Var		4	739 I	Balti	imore	Ave	nue, Hy	atts	sville,	Maryland 207
			23a. Part1. Enter the disease, or shock, or heart failure. List of	compliations that caused to	he death.									Approximate Interval Between
	Pnysician	0.0	Immediate Cause (Final disease or condition	a Disse	ctine	Thor	acte	April	to A	0.01120	it am			Onset and Death  2 days
	/Medical Examiner		resulting in death)	Due to (or as a	consequer	nce of):								z days
	Examiner	_	Sequentially list conditions,				.c Car	diov	ascu.	lar I	Disease			years
	nsit	nlne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (15 age) that initiated events	Due to (or as a	consequer	ice oi):								
,	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequer	nce of):								
760,	0 9 0	cai		d										
89	eath certificat attending phy for use as the	Medi	IE ECMALE.	1										
Вох	ath ce trendi	an/l	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	Fetal de	eath 3	Ectopic pr	egnancy					23d. Date of del Month	ivery Day Year
o.	The law requires that the death certifica lie has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at t	ime of deat	th 5	Other (sp	ecify)						,
٥.	res that the de igned by the a be detached t	Ph	Part II. Other significant conditio	ns contributing to death bu	not resulti	ng in the u	nderlying ca	ause give	n in Part I.		23e. Did to	obacco u	ise contribute to	the cause of death?
Records,	uires n sign ild be	d by									101	res 2	No 3□Pr	obably 4 Unknown
8	s been si should	Completed									24a. Was			itopsy findings available
æ	The law ate has page 2	E O									autop perfo 1 ☐ Yes	rmed?	death?	completion of cause of
Vita		0	25. Was case referred to medical						26. Place	of Death	Check only	2½ No ne)	10163	20110
>	hysic ans ce	To B	examiner? 1 ☐ Yes 2ᡯ No	Hospital: 1 ⊠ Inpatien	t 2 EF	VOutpatier	nt 3 DO	A Othe	9C 4 □ Nu	rsing Hor	me 5 Resid	lence	6 □Other (Spe	cify)
Division of	Attending Physician: r death. sctor: After this certification in the funeral director.		27. Manner of Death 1 ⊠ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28	8b. Time of Injury		8c. Injury Work	?		28d. Describe I	now injur	y occurred	
Sio	tendi leath tor: A the fu	cati	2 Accident investig	ation			М		/es 2 □		201		111 - 5	10
$\overline{\leq}$	or Attendation of Director; in by the	Certification:	4 Homicide determi		(Specify)	e, iarm, str	eet, ractory	, office		1	City or Tov	vn, State	)	ural Route Number,
	Hospital or 24 hours afte Funeral Dir tely filled in		29a. Certifier 1 🔀 Certifyin	g Physician: To the best o	my knowle	edge, deat	n occurred	at the tim	e, date an	d place, a	and due to the	cause(s)	and manner as	stated.
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	(Check only 2 Medical E	xaminer: On the basis of and manner state	examination	n and/or in	vestigation,	in my op	inion, dea	th occurre	ed at the time,	date and	d place, and due	to the cause(s)
	To the within 2 To the complet	M	29b. Signature and title of certifier	/ 1			290	License	number			29d. Dat	te signed (Mont	h, Day, Year)
	(0) (1)		) M.Co	mady	MO	)		C108				•	23/2006	
2	(14) 10		30. Name and address of person v								nolly,	M.D.	•	
	011		18109 Princ	e Phillips D	rive,	01ne	≘у. Ма	aryl:	and 2	0832				
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registra	a signatur	ha	61							
DH	MH 17 Rev 1/2		MAR & J ZU	NO PROPERTY	74	7-							- 1/55	

**ORIGINAL** 

			For State Registrar	State of N	Marylar		artment <i>rtificate</i>			nd M	-	giene Rog. No	1100	)	1246
	n ÷		Decedent's Name (First, Middle,	Last)							2. Date of De	ath		·	3. Time of Death
	Physici /Medio		PRATER	L.	DEVA	AULT					Month MARCH	23	, 2006	'ear	12:46 P <sup>M</sup>
	Examin		4a. Facility Name (If not institution,	•				Town, or L		f Death		40	. County of	Death	
2			SOUTHERN M					CLINT							RGE'S
¥	Funeral Director		413-58-0628	6. Sex 1 □ X M 2 □ F	Age (In yrs. 70	last birthday) Yrs.	If Under Months		If Under 2 Hours	Min.	8. Date of Bir (Month, Da DEC 1.	th y, Year 2 19	35 T	Birthp Cour ENN	place (State or Foreign htry) ESSEE
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation							1	0d. Inside City Limits
	Mary	ō	MD PRINC	E GEORGE'S		LAI	RGO								1 Yes 2 □ No
	r 286	Director	10e. Street and Number				10f. Zip	Code				10g. C	itizen of Wh	at Cour	ntry?
	7 wit	ai D	102 COLLEGE S	TATION DRIV	JΕ		2	0774					U.S.A	A.	
	dea m dea	Funeral	11. Marital Status	12. Was Deceder Armed Force	nt Ever in U	.S. 13.	Was Deced	ent of Hisp	oanic Orig	gin? (Spe	city Yes or No	)-	14. Race	Americ White.	
2	or it		1 ☐ Never Married 2 ☐ Marrie			VY	1 ☐ Yes 2		Specify:	, r donor	noun, orc.,		Specify:		BLACK
3	72 hours after death with the Maryland naturel', or items 23a or 28e-f ehow disal Examinar must be notified at	d by	3 Widowed 4 Divorced	Year or Dates	S:										
	"nat	Completed	15. Decedent's (Specify only highest	s Education grade completed)		(Give	dent's Usua kind of wor DO NOT us	k done du	on ring most	of workir	ng	16b. ł	Kind of Busi	ness/In	dustry
0500-61717	within ene. then "c	ᇤ	Elementary/Secondary (0-12)	College (1-40	r 5+)		US DRI						PRI	VATE	ī.
0	be filed within 72 hours after death with the Marylan Hygione.  do other than "naturel; or itams 23a or 28e-f show event, the Madical Examinar must be notified at	Be C	17. Father's Name (First, Middle, L						8. Mothe	r's Name	(First, Middle	, Maide			
Maryiand	2 should be f and Mental H is marked of raumatic eve	ToB	TED DEVAU	LT					U/K						
ם כ	s 1 and 2 should f Health and Men flem 27 is marke other traumatic		19a. Informant's Name/Relationsh	ip (Type, Print)		19b. Maili	ng Address	(Street an			i Route Numb	er, City	or Town, S	tate, Zip	Code)
	ss 1 and 2 of Health a item 27 is other train		MARY F. DEVAUL	T/WIFE		102 (	COLLEG	E ST	ATIO	N DR	IVE LAR	kGO,	MARY:	LANI	20774
9	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 17 Removal from Stat		Place of Disponentery, cre	osition (Nam matory or ot	ne of ther place)		D	ate	20c. l	ocation - C	ity or To	own, State
Ě	Pag ment ant: i		4 ☑ Donation 5 ☐ Other (Sp			RNIGAN	& SON	F.H.	. 3	3/29/	/2006	KNO	KVILLE	TE, TE	NNESSEE
paulimore,	permit. Pages 1 Department of H Important: If ite eny injury or ot once.		21. Signature - Lunctur Service-	сецген	5		2. Name and 7474 I			J	B. JE				L HOME 20785
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	complications that caus	ed the deat	th. Do not en	ter the mode	e of dying,	such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between
F	Physician		Immediate Cause (Finaf disease or condition	·Co	rebra	valu	lava	accid	int	_					Onset and Death
.S.	/Medical Examiner		resulting in death)	Due to (or a	as a consec	quence of):									
is.	Ç.	_	Sequentially list conditions,	b											
	pe psit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or t	15 3 00115 ac	paeriou uty:									
	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or a	as a consec	ruence of):								-	
0070	icate be executed physicien and sthe burial-transit	dicai E													
00	ficate p physics ts the	edic		d											
YOU	death certific e attending p id for use as	Physician/Me	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom									23d. Date	of deliv	ery
<u>ַ</u>	0 0 0	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant	at time of o		□Ectopic pre □ Other (spe						Mont	h	Day Year
	of the by th tache	hys	9 Unknown	9□ Unknown											
	8 5 8	by P	Part ff. Other significant condition	s contributing to death	but not res	sulting in the u	inderlying ca	ause given	in Part I.						he cause of death?
<u> </u>	w require been signature	ted									1 🗆	Yes :	2 □ No 3	Prol	bably 4 Tunknown
Vital Records,	e fawr has be je 2 sh	Completed									24a. Was		24b. W	ere auto	opsy findings available
֡֞֝֞֜֜֞֝֜֞֜֜֞֜֞֜֜֞֜֜֜֜֜֞֜֜֜֜֜֜֟֡֜֜֜֝֡֡֡֡֡֝֜֝֡֡֡֡֡֡֡֡֝֡֡֡֡֡֡֡	page 1	Son									perfe 1 ☐ Yes	ormed?	, de	ath?	2 10 No
<u> </u>	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?							of Death	(Check only	one)			
	Physi this o	ပ္	1 ☐ Yes 2 ☑ No	Hospital: 1 ☑ Inpa		ER/Outpatie			4 🗆 140		me 5 ☐ Res				fy)
DIVISION OF	ding l	o	27 Manner of Death 1 ☑ Natural 5 ☐ Pending		ojury Da <i>y Ye</i> a <i>r)</i>	28b. Time of Injury		8c. Injury a Work?			28d. Describe	how inj	ury occurre	đ	
2	Attending r death. ector: After by the fune	icat	2 Accident investigation inves	ot be One Pines of	Injuny - At h	ome farm of	M factors		es 2 □ l		28f Location	Street	and Numbe	or Rue	al Route Number,
<u> </u>	after Dire	Certification:	4  Homicide determin	building,	etc. (Speci	fy)	reet, lactory	, onice			City or To	wn, Sta	te)	0, 1,0,	ar route Namber,
-	To the Hospitel or Attending within 24 hours after death. To the Funersi Director: After completely filled in by the funer	edicai C	29a. Certifier 1 Certifying (Check only one)	Physician: To the be xaminer: On the basis and manner	of examina	owledge, deal ation and/or in	th occurred and oc	at the time in my opii	, date an nion, dea	d place, a	and due to the ed at the time	cause(	s) and man nd place, ar	ner as s	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				290	. License	number			29d. D	ate signed	(Month,	Day, Year)
	20		> Reit Pr	_ M.	0.		The state of the s	D 430	296			2	3.25.	06	
	(10)		30. Name and address of person w	no completed cause o	f death (Ite	m 23a) (Type	Print) 98	PAI			lon si	202	НЛ	200	4 )
	Sta	to.	31. Date filed (Month, Day, Year)	3 <b>2</b> Regi	strar's Sign	ature	- (T 7		3-7	, ,	,		100	20-1	
	Registr		MAR 2 8 2		-	A Soul	الكلا								

Amend # 26 per Phy. 3-24-06 A.A.Co.Health Dept. PM

Please Type or Print	in Black Indelible Ink.	Ensure All Copies Are Legi	bl

			For State Registrar	State of Ma				t of H	ealth a	and M	lental Hyg	giene Reg. No.	106	11247
	Physicia	an	1. Decedent's Name (First, Middle,	Last)							2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic		Ralph Stanley		r.						Mar.	22,	2006	4:45 a <sup>M</sup>
1	Examin	er	4a. Facility Name (If not institution, g 753 Stinchcomb						rna I	_		4c. Co	ounty of Death Anne	Arundel
	Funeral				e (In yrs.	last birthday)		1 Year	If Under		8. Date of Birt	h .		place (State or Foreign intry)
	Funeral Director		215-30-7660	1 <b>∑</b> M 2□F	71	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day May 23,	1934	l Cou	DE
	D *		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	ocation							10d. Inside City Limits
	Aaryle f aho	ō		Arundel	100. 01.	y, (0m. 0, E.	Joution	Sev	erna	Park	:			1 ☐ Yes 2√ No
	28a-	Director	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Cou	untry?
	72 hours after death with the Maryland Insture!; or Iteme 23e or 28e-f show disal Examinations to notified at	D B	753 Stinchcomb	Road				2	1146				U	ISA
	ama S	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U	.S. 13.	Was Deced	dent of Hi	spanic Or	igin? (Spe	ecify Yes or No- Rican, etc.)	14.	Race - Amer Black, White	
36	s afte	by FL	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		956-	1 🗆 Yes		Specify:				_	hite
8	hour	ed b	15. Decedent's	Year or Dates:	15	959     16a. Dece	dent's Usua	al Occupa	ation			16b. Kind	of Business/I	ndustry
212	within 72 ene. then "ne he Medis	plet	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5	i+)	(Give	kind of wo DO NOT u	rk done d se retired	luring mos )	st of work	ng			
21	e filed within al Hygiene. other than	Completed		5+			Sal	esma						portation
pu	D = 0 =	Be	17. Father's Name (First, Middle, La Ralph Stanley		r						e (First, Middle, .sher	Maiden Su	ітате)	
Maryland 21215-0036	should and Men amarke umatic	ဥ	19a. Informant's Name/Relationship		- •	19h Maili	ng Address	(Street a			al Route Numbe	r City or T	own State 7	in Code)
Z	ges 1 and 2 should to f Health end Men I if ttam 27 la marke or other traumatic		Nancy E. Densm								Severna	-		21146
re,	tam tam tam		20a. Method of Disposition		20b. F	Place of Dispo cemetery, cre-	sition (Nar	ne of		Mar.		20c. Loca	tion - City or T	
<u>im</u>	nit. Pages extment of I ortant: If tu Injury or or		1 ☐ Burial 2 🖾 Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			etro Cr			1	20	006'	Balt	imore,	MD
Baltimore,	permit. Page Depertment Important: If any Injury or		21. Signature of Fignerat Service Lie	Sur	2_	B 4	altran 95 Go	¢&dar& v. R	s Sons itchi	y, P. ie Hw	A. Seve	rna E rna E	Park Fu Park, M	neral Home D 21146
			23a. Pagt. Enter the disease; or co	omplications that caused by one cause on each lin	the deat	h. Do not en	ter the mod	ie of dying	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between
}	Physician		Immediate Cause (Final disease or condition	- a Processes	تمين	R Sup	ran	und	ian F	Sale	u			Onset and Death
	/Medical Examiner		resulting in death)	Due o (or as	a consec	uence of:			•					
		er	Sequentially list conditions, if any, leading to immediate	bbue to (or as	a conseq	uence of):					V			
	d d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
o,	te be executed ysicien end te burial-transit		resulting in death) Last	Due to (or as	a conseq	uence of):								
8760,	2 2 2	lcal		d										
89 X	death certificat e attending phy d for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregna	ancv						22	d. Date of deli-	··oa/
Вох	atten atten	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Feta	Ideath 30	☐Ectopic po ☐ Other (sp					230	Month Month	Day Year
o.	y th	hysl	1 Yes 2 No 9 Unknown	9□ Unknown										
S,	The law requires that ite has been signed b	by P	Part II. Other significant condition	s contributing to death b	ut not res	ulting in the u	inderlying o	ause give	en in Part	1.	23e. Did to			the cause of death?
Vital Records,	w require been si should I										101	es 2 <b>7</b> 8	No 3□Pro	bably 4 Unknown
Sec	e law has b	Completed									24a. Was autop		24b. Were aut prior to c death?	topsy findings available ompletion of cause of
교	ilcian: The l certificate ha rector, pege			-							1 X Yes	2 No	1 Yes	25 No
ž	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	ent 2	ER/Outpatie	nt 3 🗆 DC	Othe	25		n <i>(Check only o</i> me 5 <b>X</b> Resid		Other (Spec	Aristo Lin
1 of		-	27. Manper of Death	28a. Date of Inju (Month, Da	ry	28b. Time o		28c. Injun	at at		28d. Describe h			S MAINTERESTOR
ior	Attending r death. sctor: After by the fune	atio	1 Natural 5 Pending 2 Accident investiga	tion	, , , , ,	пдагу	М		Yes 2	No				
Division	l or Attandatter deatl Director:	Certification:	3 Suicide 6 Could no 4 Homicide determin		ury - At h c. <i>(Speci</i> i	ome, farm, st fy)	reet, factor	y, office			28f. Location (S City or Tox	Street and I vn, State)	Number or Ru	ral Route Number,
_	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical C	29a. Certifier Certifying (Check only one) Certifying	Physician: To the best taminer: On the basis o and manner sta	f examina	owledge, deat ation and/or in	h occurred evestigation	at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to the e	cause(s) ar date and p	nd manner as lace, and due	stated. to the cause(s)
	To the within 2 To the complet	Μe	29b. Signature and title of certifier	00			290	c. License	nedmun e			29d. Date .	signed (Month	, Day, Year)
			Erik L. Kus	rellemi	7		D	43	102	3		031	2310	00
			30. Name and address of person w	MD. 77	7/1(	Lucirte	Print	d k	A Clo	n Ru	rnie 1	为。	2106	51
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registr	ar's Sign	ature	R.		1		)			

		•	For State Registrar	State of I	Maryland		artmeni tificate			nd Me		jiene eg. Nő.	06	11248
	Physici /Medic	al	Decedent's Name (First, Middle, Lasi     Anastacia Ga     4a. Facility Name (If not institution, give	il Davis			4b City	Town or	Location of		2. Date of Dea Month March	22,	Year 2006 County of Deatl	3. Time of Death
	Examin Funeral Director	er	9512 Rosevale Str 5. Social Security Number 6. Se	eet 7.	Age (In yrs. iz	ast birthday) Yrs.		Was	shingt If Under 2 Hours	on	B. Date of Birth (Month, Day 1/10/64	Pr	ince Ge	
		Director	Usual Residence of Decedent  10a. State 10b. County  Md •  10e. Street and Number	P.G.	10c. City	Fort			on				en of What Co	10d. Inside City Limits 12€ Yes 2 ☐ No
020	within 72 hours after death with the Maryland ene. Then "naturel", or items 23a or 28a-f ehow na Medical Examiner must be notified at	by Funeral	9512 Rosevale (	12. Was Decede Armed Force 1⊠Yes 2	is? □ No		Was Deced f Yes, spec			in? (Spec Puerto R	orfy Yes or No- lican, etc.)			rican Indian,
N .	Hygir ther int, L	e Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0·12)		or 5+)	life.	dent's Usua kind of wor DO NOT us aff A	rk done d se retired	during most ) Stant		g (First, Middle,	U		Industry Vernment
	d 2 should be hand hand hand hand hand hand hand hand	To Be	Laurence T. Davis  Juanita Nickens  19a. Informant's Name/Relationship (Type, Print)  Juanita N. Davis/Mother  20a. Method of Disposition  1 Burial 2 *** Cremation 3 Beamoval from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  4 S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Wash., D.C. 2											
Dallillore,	permit. Pages 1 and 2 Department of Health Important: if item 27 I eny injury or other tra once.												Town, State	
改革 一十十年	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Metas	sed the death h line. Static as a consequ	Colon	er the mod	e of dyin	oughs g, such as c	Ave.	N.E., W	ash.	,D.C.	Approximate Interval Between Onset and Death
	ite be executed ysician and ne burial-transit	Ical Examiner	Sequentially list conditions, I any leading to infined at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	as a consequ									
.0.	The law requires that the death certifical site has been signed by the attending phypege 2 should be detached for use as the	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown		n 2 □ Fetal tat time of de	death 3	Ectopic pr					2	3d. Date of del Month	ivery Day Year
1000	w requires tha been signed I should be det	þ	Part II. Other significant conditions of	entributing to deat	h but not resu	ulting in the u	ndertying c	ause giv	en in Part I.	_	1 🗆 Y	es 2	No 3□Pr	othe cause of death?  obably 4 Unknown
אומו חפי	sician: The lav certificete has rector, pege 2:	Be Completed	25. Was case referred to medical examiner?								(Check only o	sy med? 2 No	prior to death?	topsy findings available completion of cause of 2 □ No
5 5 6	ling Phys  After this uneral di	Certification: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of I (Month,	atient 2 🗆 l njury Day Year)	ER/Outpatier 28b. Time o Injury		8c. Injur Wor		21	e 5 Resid		Other (Spec	cify)
DIVISION	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the formulation of the f		3 Suicide 4 Homicide  6 Could not be determined  29a. Certifier (Check only 2 Medical Exam	building,	etc. (Specify	/) wledge, deat	h occurred	at the tin	ne, date and	f place, ar	City or Tow	ause(s)	and manner as	s stated.
/	To the H within 24 To the F complete	Medical	29b. Signature and title of certifier		stated.	1	290	D43	e number 361			29d. Date	a signed (Monta	h, Day, Year)
	Sta Registr		30. Name and address of person who can be seen and address of person who can be seen as a seen and address of person who can be seen as a seen as	ia Ave.,	NW .	20037		Robe Was	shingt	_	, M.D.			

AEM 06-02025 Ruth

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

llard	1	For State	State of Marylan			nt of H te of L		Men				
B		Registrar  1. Decedent's Name (First, Middle, La	st)		unca	ie oi L	Jealii	2.0	Reg. Date of Death	No.	<del>)                                    </del>	3. Time of Death
Physician	1	Ruth	Diggs	I	)illa	ard			wonth arch 2	Day 2	Year 006	11:32A
/Medical Examiner		a. Facility Name (If not institution, given	e street and number)		4b. Cit	, Town, or	Location of Deat				nty of Death	
		Prince George's				Chevei		1:		Pri		orge's
Funeral Director		579 18 1039	Sex 7. Age (In yrs.			or 1 Year Days	If Under 24 Hrs. Hours Min.	De	Date of Birth Month, Day 19	920	9. Birthp Wash	lace (State or Foreign 1979). C.
* =	-	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limit
de la la la la la la la la la la la la la	2	D.C.		Washi	ngto	n,D.C	•					1 Q Yes 2 □ N
Depertment of Health and Mental Hygiene. Important: if itsm 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic svent, the Medical Example must be notified at once.  To Be Completed by Finners Director	Direc	10e. Street and Number 133 Ingraham Str	eet,N.W.		10f. Z	ip Code 2001	11 -		10g.	. Citizen d US	of What Cour	itry?
rmms 2	le s	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Dec	edent of Hi	spanic Origin? (S n, Mexican, Puer	pecify	Yes or No-		lace - Americ	
al', or its Examina by Eur	Dy ru	1 Never Married 2 Married 3 Nover Married 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:			2 No	Specify:	io riica	11, 6(6.)		cify: Blac	
natura lical	) ted	15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Us	ual Occupa	ation during most of wo	rkina	161	b. Kind of	Business/In	dustry
ene. than "natural", or items 23a or 28a-f show he Medical Ezaratrat must be notified at homological by Eumaral Director	E	Elementary/Secondary (0-12)	5 years	life.	ncip:	use retired,	)	g	D.	.c. s	School	System
Hygie ther the nat, the	် ရ	17. Father's Name (First, Middle, Lasi					18. Mother's Nar	me (Fir				
Mental arked o atic ave	o ne	James T. Digg		,					Diggs -			
alth and 27 is m or traum		19a. Informant's Name/Relationship, Brian Dillard /	Type, Print) Son	2307	SO 1	ss (Street a nar D	r. Silve	Sp	ring,M	20	m State, Zip 1904	Code)
ant of Hei It: if Itam y or othe		20a. Method of Disposition  1 🌣 Burial 2 □ Cremation 3 [  4 □ Donation 5 □ Other (Speci	Removal from State T. 11	Place of Disponentery, crein ncoln	natory of	other place	3/25	Date / 20			and, MD	
Depertme mportan my injur-		21. Signature of Funeral Service Lice	A 12.2	J.	2. Name OHN	and Addres	is of Facility INES FUN	ERA	L HOME,	, INC		
03.00	+	23a. Partz. Enter the disease, or con	unlications that caused the deat	h Do not en	3015	12th	ST., N.E	W	ASH.,D.	.C. 2	20017	Approximate
an and rial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence of a con									
a 🗘 🛁	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2 M No 9   Unknown	23c. If yes, outcome of pregn; 1  Live birth 2 Feta 4 Pregnant at time of c	I death 3	⊒Ectopic ⊒ Other (	pregnancy specify)					Date of delive	ery Day Year
e de d	2	Part II. Other significant conditions  Circhosis of IIVe		ulting in the u	nderlying	cause give	en in Part I.		23e. Did tobac	11		ne cause of death?
- O	Completed								24a. Was an autopsy performe		b. Were auto prior to co death? 1 11 Yes	ppsy findings availal mpletion of cause of
certificete	O	25. Was case referred to medical					26. Place of De	ath (C/		140	1,03	2010
is certific	90	examiner? 1 ∑rYes 2 ☐ No	Hospital: 1 ☐ Inpatient 25€	ER/Outpatie	nt 3 🗆 I	Oth	ar		5 Residence	ce 6 □0	Other (Specif	'y)
After t funera		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f M	28c. Injun Work	yat k? Yes 2 □ No	28d.	Describe how	injury occ	curred	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Certification:	3 Suicide 6 Could not determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, st fy)	reet, lact	ory, office		281.	Location (Stree City or Town,		imber or Rura	al Route Number,
Funer Funer stely fill	Medical C		hysician: To the best of my kno miner: On the basis of examina and manner stated.									
within To the comple	Me	29b. Signature and title of certifier	1		2	9c. Licens	e number		290	l. Date sig	gned (Month,	Day, Year)
		Pamet Sign	thall, mi)	n 22c) (T	Del-1	OCM	E			Marc	h 23,	2006
			completed cause of death (Item			l Pen	n Street	Ва	ltimore	e, Ma	ryland	1 21201
State		31. Date filed (Month, Day, Year)  MAD 2. 7. 2001	32. Registrar's Sign	ature	6,							

	4	For Stete Registrar	Stat	e of Ma	rylanc	•	artmen rtificate			and M	ental Hy	Reg. N	UUi	5	112	50
Physician		Decedent's Name (First, Middle,     Manage and a tree and a t	Last)	ъ.			_				2. Date of De Month	eath Da	ay	Year	3. Time	of Death
/Medica		Margaret		В.			Dra				March	- 7		006	4:0	0 р <sup>1</sup>
Examine	r	4a. Facility Name (If not institution,		-					Location of	of Death		40	c. County o	f Death		
		Crofton Conval					L	ofto		0411			Anne			
Funeral			Sex 1 □ M 2X		i (in yrs. ia 80	st birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bi (Month, D	rth a <i>y, Year</i>	2006	9. Birthp Cour	lace (Stat ntry)	e or Forei
Director	+	263-44-2392 Usual Residence of Decedent			00						Feb. 1	5, 1	926	Ten	nesse	<u>e</u>
land	ľ	10a. State 10b. County			10c. City,	Town or Lo	cation							1	0d. Inside	City Limit
Many teh	គ្គ	MD Anne A	runde1		G	ambri:	lls								1 □ Y	es 2 <b>▼</b> ∏N
death with the Maryland ms 23s or 28e-1 ehow Irrust be redified at	Director	10e. Street and Number					10f. Zip	Code				10g. C	itizen of W	hat Cour	ntry?	
3a o	2	2413 Arapaho W	ay				2	1054					USA			
	runerai	11. Marital Status	12. Was	Decedent E	ver in U.S	. 13.				gin? (Spe	ocify Yes or N Rican, etc.)	0-	14. Race		an Indian	,
hours after turel, or ite	2	1 ☐ Never Married 2 ☐ Marrie	1 1 0	ed Forces? Yes 201N es, Give	o	-	1 ⊡Yes :			i, rueito	nican, etc.)			, White, τ		
₹ <b>- 3</b> 1	20	3 X Widowed 4 □ Divorced	Yea	r or Dates:			1 1 1 63	2 (21 140	эрвспу.				Specify:	'	White	
72 hours "neturel", dical Ex	Сотріете	15. Decedent's (Specify only highest	Education grade comple	eted)		16a. Dece	dent's Usua kind of wo	l Occup	ation du <i>ring m</i> osi d)	t of worki	ng	16b. I	Kind of Bus	siness/In	dustry	
C36	d F	Elementary/Secondary (0-12)	Coll	ege (1-4or 5	+)				1)							
e filed w all Hygier other th		12				Home	emake	r	40.11.11	4. 61.	<b>(5:</b>		wn Ho			
be fill Hall Hall Hall Hall Hall Hall Hall H	g R	17. Father's Name (First, Middle, Li	ist)								(First, Middle			")		
2 should be 1 and Mental I ie marked of reumetic eve	<u> </u>	John T. Buntin									rd Hud	<u> </u>				
s 1 and 2 should be filed within theelth and Mental Hygiene. Item 27 is marked other than other treumetic event, Item 77 B. D. Comments		19a. Informant's Name/Relationshi		•			-	•			I Route Numi				Code)	
and feelth m 27 her t	-	Kathleen Furna	S (Dau	gnter)							rills,					
permit. Pages 1 and 2: Department of Heelth at Importent: If item 27 ie any injury or other treuonce.		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	Removal	from State		ace of Dispo metery, crea			(e)		ale	20c. l	ocation - (	iny or io	own, State	
men tent: jury		'4 □ Donation 5 □ Other (Spe			Met	ro Cre					-2006	Ва	ltimo	re,	MD	
ermit epar npor ny in DCE.		21. Signature of Funeral Service Li	censee		_	22	Name an Harde	d Addre	ss of Facilit Fune	y ral	Home,	P . A .				
205 a a	4	23a. Part 1. Enter the disease, or c					12 R:	<u>idge</u>	<u>ly Av</u>	enue	. Anna	poli	s, MI	214	401 Approxin	
Medical Examiner He burial-itansiti	ii Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b	ue to (or as a	a conseque	ence of):										
the the	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1	es, outcome of Live birth Pregnant at Unknown	2 ☐ Fetel of time of dea	death 3[ ath 5[	Ectopic produced of the control of t	ecify) _			23e. Did	tobacco	23d. Date Mon	th	Day	Year
		QUADR	PAR	ESIS							1 🗆	Yes 2	No	3 🔲 Prot	ably 4	□Unkno
s baen si should	Completed										24a. Wa		24b. W	/ere auto	psy findin	gs availa
The lav	Ē										perf	omed?		nor to co eath? □ Yes	mpletion o	it cause
	e l	25. Was case referred to medical						-	26 Place	of Death	1 ☐ Yes	2 N	0 1	1 1 62	2LI NO	
	0	examiner? 1 Yes 2 YNo	Hospital:	1 🗆 Inpatie	nt 2∏E	R/Outpatier	at 3□ DC	A Oth	OP A	rsing Ho			6 □Othe	r (Specif	(v)	
Physe eral di	-	27. Manner of Death	28a.	Date of Injur	y :	28b. Time o		8c. Injur Wor			28d. Describe				77	
Attending ler death. ector: After by the funer	Certification:	1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e.	(Month, Day	iry - At hon	Injury	М	1 🗆	K? Yes 2□		28f. Location City or To			r or Rura	al Route N	umber,
Hospi 14 hou Funer Telly fill	ledical Cer	29a. Certifier 1 Certifying (Check only one) 2 Medical E	Physician: 'kaminer: On	To the best of	of my know examination	rledge, deat	h occurred vestigation	at the tir	ne, date an pinion, dea	d place, th occurr	and due to the	e cause(	s) and mar	ner as s	tated.	e(s)
thin 2 the orthe	Mec	29b. Signature and title of certifier	and	a marmor sta			290	. Licens	e number			29d. D	ate signed	(Month.	Day, Yea	r)
To Yeith		1/20 /	1 11)	00		(1.0										
		30. Name and address of person w	ho completed	d cause of de	eath (Item	23a) (Type,	Print)	NO	1136	?	RD, E	MA	KCH	21,	200	16
		BRIAN C.	WAL	LACE	my	,900	05/	KIL	BRII	DE 1	RD, E	BALI	mo	RE,	MD	112
State Registra		31. Date filed (Month, Day, Year)	M6 &	32. Registra	r's Signatu	Ife C	do				,			,		

epa me

		1 - For State Registrar	e of Maryland / Dep <i>Ce</i>	artment of He rtificate of D			iene)) (	11251
Physic	ian	Decedent's Name (First, Middle, Last)	2 0'11			2. Date of Death Month	28 200°	3. Time of Death
/Medi	cal	Henr  4a. Facility Name (If not institution, give street and	y A. Dill	4b. City, Town, or L		March	4c. County of I	
Examir	ner	Ellicott City Nursing	& Rehab	Ellicot	t City		Howa	rd
Funeral Director		5. Social Security Number 6. Sex 215 01 9108 6. Sex	F 93 Yrs.	If Under 1 Year     Months Days	Hours Min.	B. Date of Birth (Month Day,	1913 I	Birthplace (State or Foreign Mary Land
yland now		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
e Mar	ctor	MD Howard	Elli∞tt	: City				1 ☐ Yes 2 No
with th	Dire	10e. Street and Number		10f. Zip Code 21043		10	og. Citizen of Wha United	,
Jeath v	eral	8700 Ridge Road #107	Decedent Ever in U.S. 13.	Was Decedent of Hisp	panic Origin? (Sp	ecify Yes or No-		American Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene are returned: I feel at 1 is marked other then "netural", or items 23a or 28a-f show any njury or other traumatic event, The Medical Evantinar must be notified at ance.	Completed by Funeral Director	Arme 1 Never Married 2 Married 1 Yes	d Forces? Yes 25 No G, Give or Dates:	If Yes, specify Cuban,	Mexican, Puerto Specify:	Rican, etc.)		White, etc. White
72 hor	eted	15. Decedent's Education (Specify only highest grade comple	ted) 16a. Dece	edent's Usual Occupati Skind of work done du	ion ring most of work	ina 1	16b. Kind of Busin	ness/Industry
od within 72 hours aff giene. er then "netural", or , the Medical Exami	mpi		ge (1-4or 5+) life.	DO NOT use retired) Less Cable			Western 1	Electric
filed Hygie other	Be Co	17. Father's Name (First, Middle, Last)	WILCI			e (First, Middle, M		<u> </u>
Menta Menta Mrked artic ev	To B	Frederick C. Dill		N	largaret	ta 1	unknown	
od 2 should be file Ith and Mental Hy 27 is marked oth traumatic event	1 2	19a. Informant's Name/Relationship (Type, Print, Joan Kurtz/Step Daughte		ing Address (Street an				ate, Zip Code)
s 1 and f Healt item 2 other		20a. Method of Disposition	20b. Place of Disp	osition (Name of matory or other place)			20c. Location - Cit	y or Town, State
Page: nent o ent: If ury or		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal f  `4 ☐ Donation 5 ☐ Other (Specify)	rom State	.dge Cemete	1	L-2006 1	Elkridge	, MD
permit. Deports Imports any nji		21. Signature of Funeral Service Licensee						Family FH Ind ty, MD 21043
		23a. Part1. Enter the disease, or complications to shock, or heart failure. List only one cause	hat caused the death. Do not en					Approximate Interval Between
Physician		Immediate Cause (Final disease or condition resulting in death) a	and a	age	revol	kul	me	Onset and ath
/Medical Examiner		Du Du	e to (or as a consequence of):	-		0		70
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e to (or as a consequence of):		200	1.		202
ecuted and -transi	Examiner	that initiated events c.	e to (or as a consequence of):	430	who	1		20 ge
icate be executed physician and s the burial-transit	dical E		5 to (51 us u 551155quarios 51).					9
		IE ECMALE.						
death certifi e attending I id for use as	ian/I	in the past 12 months?		Ectopic pregnancy			23d. Date of Month	f delivery Day Year
0 9 6	nysic		Pregnant at time of death 5 [ Jinknown	Other (specify)				
Se oc	d by Physician/M	Part II. Dther significant conditions contributing	to death but not resulting the	underlying cause given	in Part I.	23e. Did tob		ite to the cause of death?  Probably 4 ☐Unknown
- 40	Completed					24a. Was ar autopsy	24b. Wer	re autopsy findings available r to completion of cause of
The ate h page	Com					perform	ned? dear	th?
Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?  Hospital:		Other		(Check only one	·	
Phys this aldi	7: To	27. Manner of Death 28a. D	1 ☐ Inpatient 2 ☐ ER/Outpatie	of 28c. Injury a	443 Nursing Ho	me 5 Resider 28d. Describe ho	nce 6 Other (	(Specify)
Attending or death. ector: After by the fune	atio	1 Matural 5 Pending ( 2 Accident investigation (	Month, Day Year) Injury	Work? M 1 ☐ Ye	es 2 □No			
al or Attending s after death. I Director: After d in by the fune	Certification:	3 Suicide 6 Could not be determined 28e. F	Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office		28f. Location (Str City or Town		or Rural Route Number,
To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Medical C	(Check only 2 Medical Examiner: Qn t	o the best of my knowledge, dear he basis of examination and/or in manner stated.	th occurred at the time nvestigation, in my opir	, date and place, nion, death occurr	and due to the ca ed at the time, da	use(s) and manne ite and place, and	er as stated. I due to the cause(s)
To th within To th comp	Me	29b. Signature and title of certifier	arala	29c. License r	number	29	d. Date signed (A	Nonth, Day, Year)
		• 4>	5	7)	117	VO M	arch 28,	2006
ز		30. Name and address of person who completed	sause of the att (Item 23a) Type	Print) A	7670	Calve	Flow &	t bolting 121
Sta	ate		32. Registrar's Signature	•				25111112
Regist	rar	MAR 2 8 2006	Elegen 15	Brand 1				

			For State Registrar		State o	f Mary	/lanc				lealth : Death		lental Hy	giene Reg. No.	106	112	:52
			1. Decedent's Name (First, Min	ddle, Last)				2. Date of De		Year	3. Time o	of Death					
	Physici /Medio			Je	erome	E. D:	iet	rich					March	26	2006	7:10	PM
	Examir		4a. Facility Name (If not institu	tion, give st	reet and nu	mber)			4b. City	, Town, o	r Location	of Death			unty of Deat		
_			Gilchrist Hos			7 4 //-		and the final trade of the		TOWS		24 Hrs	0.0(8)		Baltin		
pm	Funeral Director		5. Social Security Number	6. Sex	M 2□ F		n yrs. Ia	ist birthday) Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da May 17	ıy, Ye <i>ar)</i>	Co	hplace (State untry) vland	or r-oreign
6			212 07 5216 Usual Residence of Decedent			86			<u> </u>				May 17	, 191.	7 Mai	утани	
	larylan show		10a. State 10b. Cou	nty		10		Town or Lo								10d. Inside (	·
-26-06	the Ma 28a-f s	cto	MD How	ard			E1:	licott		<del>-</del>						L	s 2 No
9	with the Port	Dire	10e. Street and Number							p Code				10g. Citizen	of What Co	untry?	
3	eath w	erai	3434 Jay Drive		2. Was Dec	edent Ever	r in II S	13		042	Henanic Or	inin? (Spe	ecify Yes or No		ed Sta	tes	
3	us after death with the Maryla ai', or itema 23a or 28a-f sho Exercimet mant be notified at	by Funeral Director	1 ☐ Never Married 2√2 M		Armed For 1 Yes If Yes, Gir	rces?			If Yes, sp	cify Cuba	an, Mexica	n, Puerto	Rican, etc.)		Black, White	e, etc.	
5	Sours a Sur, o		3 ☐ Widowed 4 ☐ Divord	bes	If Yes, Gir Year or D	ates: 1	945		1 🔲 Yes	2 <b>X</b> No	Specify.	:		Sp	<sup>ecify:</sup> Whi	.te	
0177E	FIX IS-UUSO I within 72 hours after death with the Maryland lene lene rithen "natural", or items 23s or 28s-f show it e Medical Examination in the incilination	Completed	15. Deced (Specify only hig	lent's Educa he <i>st grad</i> e				16a. Dece (Give	kind of w	ork done	durina mos	st of worki	ing		of Business/		
erome	within than	gm	Elementary/Secondary (0-12	2)	College (	1-4or 5+)		Machi	DO NOT		-/			Manua	actur	or	
	D O		17. Father's Name (First, Midd	lle, Last)				FIACILI	тпос	FOL		er's Name	(First, Middle	<del></del>		ET	
Le E	2 d a b §	To Be	Jerome E. Die	trich							Minn	ie B	urns				
) / C	ice, Maryland s 1 and 2 should be file Health and Mental Hy Itam 27 is marked oth other traumatic avant		19a. Informant's Name/Relation			<b>.</b>			-				t City,			Zip Code)	
		1	20a. Method of Disposition		-,	-	20b. Pla	ace of Dispo	sition (Na	me of	1		ate			Town, State	
ietric	0 0			2□ Burial 2□ Cremation 3□ Removal from State 4□ Donation 5□ Other (Specify)  **Cemetery, crematory or other place)  St. John's Cemetery 3-30-20											ott C	ity, M	D
2	permit. Pag Department Important: I any injury o		21. Signature of Funeral Servi		11/	2 MO:	104						ry H. W				
à	Dermi Depa Impo		I have Col	Uns	- hill	gle		4	112	01d (	Colum	bia 1	Pike El	licott	: City	, MD 2	1043
•	Physician /Medical Examiner		23a. Par1. Enter the disease, shock, or heart failure. L Immediate Cause (Final disease or condition resulting in death)	or complication on the control of th	a cause on e	caused the sach line.	977	DNS 0	0	-	_		d 13-			Approxima Interval Be Onset and	ate etween Death
0928	of ou, cate be executed bhysicien and the burial-transit	dical Examiner	Sequential, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	d.		(or as a co											
A VOE	eath certific ettending p	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23		oirth 2. ☐ nantattime	Fetal	death 3□	Ectopic p		y			23d	Date of deli Month	ivery Day	Year
<u>و</u> د	requires that been signed?	ed by P	Part II. Other significant cond	litions conti	nbuting to d	eath but no	ot resu	lting in the u	nderlying	cause giv	en in Part	l. 	23e. Did t	-1		the cause of obably 4	
ç	e law requ	Completed											24a. Was	an 2	4b. Were au	topsy finding	s available
à	The lav	E											perto	ormed?	death?	2 □ No	cause or
<u> </u>	ysician: Thysician: The is certificate director, pag	Be	25. Was case referred to med examiner?								26. Place	e of Death	(Check only	one)			
<b>(</b>	Physic this c	မ	1 Yes 2 No	Но		Inpatient		R/Outpatier			4 14		me 5 ☐ Resi			ciny No sp	PTQ
5	E e e	tlon	27. Manner of Death 1 Shatural 5 ☐ Pen	iding istigation	28a. Date (Mon	th, Day Ye	ear)	28b. Time o Injury	м	28c. Injur Wor	yan rk? Yes 2.⊟		28d. Describe	now injury or	currea		
Olivicion of Vital Bosonal	To the Hospital or Attending within 24 hours effer death. To the Funeral Director: Affei completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Cou	ild not be ermined	28e. Place build	of Injury - ing, etc. (S	- At hor Specify)	ne, farm, str					28f. Location ( City or To		umber or Ru	ıral Route Nu	m <i>ber</i> ,
	ne Hospil 124 hour ta Funari letely fills	Medical (	29a. Certifier (Check only one)	ying Physical Examine	er: On the b	e best of m asis of exa ner stated.	aminati	rledge, deat on and/or in	h occurred vestigatio	at the tir n, in my o	me, date ar opinion, dea	nd place, a ath occurr	and due to the ed at the time,	cause(s) and date and pla	d manner as ce, and due	stated. to the cause	(s)
	To the withing To the comp	M	29b. Signature and title of cert	ifier	. 1		_		29	c. Licens	e number			29d. Date s	gned (Monti	h, Dey, Year)	
•	l		XXX	100	20	w	)		1.5	D58	3303	, >		Mar	ch a	7 200	6
(0)	02		30. Name and address of pers	on who corr	npleted caus			23а) (Туре,					Times	m2	12001		
(5)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Amon Charles m (601 N Charles It Patting m) 2/2 of  State 31. Date filed (Month, Day, Year) 32. Relistrar's Signature															
	Sta Registi			8 20		gistrar S	Jigi idil	dre	Const								

DHMH 17 Rev 1/2001

		For State Registrar	State of Marylan			nt of He		d Ment		iene	16	11253
Physic	cian	1. Decedent's Name (First, Middle, Las	•					M	ate of Deat onth		Year 06	3. Time of Death
/Med Exam		Constance Del	e street and number)	<u> </u>		_	ocation of D		<i>J</i> 3	4c. Coun	ity of Death	12:07 P M
Funera Directo		216-06-83/4		last birthday) Yrs.			If Under 24	Hrs. 8. Da Min. (M	ate of Birth fonth, Day,			place (State or Foreign
Maryland a-f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Prince Ge		y, Town or Lo ndover								10d. Inside City Limits  1X Yes 2 □ No
with the	i Direc	10e. Street and Number 3111 Manson Plac	e		10f. 2	ip Code 2078	5		1	og. Citizen o	f What Coul	•
Tarry Italica (2.12.13-0030) 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene and Mental Hygiene is marked other than "natural", or items 23a or 28a-1 show aumatic event, the Mariles Experiment aumatic event, the Mariles Experiment aumatic event.	by Funeral Director	11. Marital Status  12 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 □Yes 2X No If Yes, Give Year or Dates:	.S. 13.		edent of His ecify Cuban	panic Origin , Mexican, P Specify:	? (Specify Y uerto Rican	es or No- , etc.)	14. R	ace - Americack, White,	can Indian, etc.
KIKID-UUSO d within 72 hours at giene. er then "natural", or the Mudics Ext. n	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12)		(Give	kind of v DO NOT	use retired)	ion uring most of	f working		16b. Kind of	Business/In	dustry
Maryland And 2 should be filed with and Mental Hygiel 27 is marked other traumatic event, the present of the contraction of the	To Be Co	12 17. Father's Name (First, Middle, Last, Unknown		Sur	œrvi			Name (Firs		Maiden Sum		lces/Privat
12 gg C	-	19a. Informant's Name/Relationship (  Michael J. Fdmur.  20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □	ds -Brother		1 Mar	nson P	lace,		ver,	r, City or Tow MD 20 20c. Location	785	
Baltimore, permit. Pages 1 a Department of Her Important: if item any injury or othe		4 Donation 5 Other (Specification of Funeral Service Licer	v) Che	//	2. Name	and Address	of Facility	Strick	land	Beltsv Funer Spring	al Sei	rvices
Pnysiciar /Medica	ı	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused the deat one cause on each line.  a. Motastatic Due to (or as a consec	Breast			, such as car	rdiac or resp	piratory arr	est,		Approximate Interval Between Onset and Death 18 months
sate be executed whysician and the burial-transit out	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diease of Krjur) that initiated events resulting in death) Last	b									
box od fou, death certificate be ex e attending physician d for use as the burial	cai	IF FEMALE: 23b. Was decedent pregnant	_d							23d. I	Date of deliv	ery
by the	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown		□Ectopic □ Other (	pregnancy specify)					Month	Day Year
KECOTUS, P. he law requires that e has been signed b age 2 should be deta	b	Part II. Other significant conditions	contributing to death but not res	sulting in the	underlying	g cause give	n in Part I.		23e. Did to 1 ☐ Y			the cause of death?
- tag	Completed							1	-	sy med? 2 <b>∑</b> No	prior to co death?	opsy findings available ompletion of cause of
Phys ral di	ition: To Be	25. Was case referred to medical examiner?  1 Yes 2X No  27. Manner of Death  1X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time Injury	of	28c. Injury Work	r: 4 🗌 Nursi	28d. [	5 🗌 Resid	ence 6 0 ow injury occ		fy)
2 p 4 2 2	Certification:	3 Suicide 6 Could not be determined			treet, fact	ory, office			ocation (S lity or Tow		mber or Rur	al Route Number,
the Hospital hin 24 hours a the Funeral (	edical	29a. Certifier 1 ☆ Certifying Pl (Check only one) 2 ☐ Medical Exer	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, dea ation and/or i	ith occurre nvestigati	ed at the time on, in my op	e, date and p inion, death	place, and d occurred at	ue to the c the time, c	ause(s) and date and plac	manner as : e, and due !	stated. to the cause(s)
To the within To the	M	29b. Signature and title of contifier	MD-		2	9c. License			2	29d. Date sig		
R (5)	)	30. Name and address of person who Chnra Zenkatram		m 23a) (Type 1 Gree	enbel	D417. t Road		lege :	Park,		h 28,	Suite U#3
S Regis	State Strar	31. Date filed (Month, Day, Year)  MAR 2 9 200	. Registrar's Sign	ature								

			_ FOI	partment of Health and Mental Hygertificate of Death	piene() () 6     254
			Decedent's Name (First, Middle, Last)	2. Date of Dea	th 3. Time of Death
	Physicia /Medic		Bessie Viola Ellis	March 2	7, 2006 6:33 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
4			Southern Maryland Hospital	Clinton  Ji If Under 1 Year   If Under 24 Hrs.   8 Date of Birth	Prince George's
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 TXF 7. Age (In yrs. last birthda) 86 Yrs.	w) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. July 13	(, Year) Country)
	ס		Usual Residence of Decedent		
	anytan show	_	10a. State 10b. County 10c. City, Town or I	_ocation	10d. Inside City Limits
	8a-f	Director		larlboro	1 □Yes 3√□No
	a or	Dir	109. Street and Number		10g. Citizen of What Country?
	ne 23	Funeral	10735 Crain Highway  11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Specify Yes or No-	USA 14. Race - American Indian,
21215-0036	be filed within 72 hours efter death with the Maryland ital Hygiene. Id other then "natural", or tleme 23a or 28a-f ehow event, the Medical Examinar must be notillised at	by	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married Forces?  1 Never Married 2 Married Forces? 1 Never Married 2 Married Forces? 1 Never Married 2 Married Forces? 1 Never Married 2 Married Forces?	If Yes, specify Cuban, Mexican, Puérto Rican, etc.)  1 ☐ Yes 2 ☑ No Specify:	Black, White, etc.  Specify: White
5-0	72 ho	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of working	16b. Kind of Business/Industry
121	vithin ne. hen "	mpi	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker	0 11
	o filed within al Hygiene. I other then 'vent, the Me		8 17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle,	Own Home  Maiden Sumame)
Maryland	should be nd Mental marked o	To Be	Wade Hamilton Windsor	Mary Alice K	
ary	s mai		19a. Informant's Name/Relationship (Type, Print)	iling Address (Street and Number or Rural Route Number	
Σ.	and 2 ealth n 27 i			5 Crain Highway, Upper Mar	rlboro, MD 20772
ore	ges 1 if of H if Itea or oth			ematory or other place)	20c. Location - City or Town, State
Baltimore,	it. Pa rtmen rtent: njury		De otalis Automosto Contraction	Memorial Gdns 3-31-2006	Waldorf, MD
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Importent: if Item 27 is marked any injury or other traumatic ev		MUUU03	3035 (	Old Washington Road 56, Waldorf, MD 20604
			23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.		1 2
	Physician			Respiratory For	Onset and Death
	/Medical Examiner		Due to (or as a consequence of).	/	
£.		3.	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence oi):	'c shock	
	uted 1 ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c. 31 2017 872	e Portumonia	and
ó	exec en an		resulting in death) Last Due to (or as a consequence ol):		0
8760,	cate be executed physicien and the burial-transit	dical	Conge	shive Items fo	allure
$\mathbf{\Theta}$		0	IF FEMALE: 23c. If yes, outcome of pregnancy		
Вох	death certific e attending p id for use as	Physician/M	in the past 12 months?	B Ectopic pregnancy C Other (specify)	23d. Date of delivery  Month Day Year
P.O.	0 0 0	hysi	1   Yes 2   No 9   Unknown 9   Unknown		
	The law requires that the ste has been signed by the bage 2 should be detache	by P	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did to	bacco use contribute to the cause of death?
ord	equire sen si ould b		told Silvelia (	concer of preast	'es 2 □ No 3 □ Probably 4 □Unknown
eco	has be	ompleted	Hypertensive brant	dr Fe ase 24a. Was a autop	sy prior to completion of cause of
a H		ပ	Chrosic obstanting	lung bisease 10 Yes	med? death? 2 No 1 Yes 2 No
Z.		o Be	25. Was case referred to medical examiner?  Hospital: Hospital:	26. Place of Death (Check only of	
ō	ding Phys h. After this funeral di	<b>—</b>	1 Yes 2 No 1005 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	ol 28c. Injury at 28d. Describe h	lence 6 Other (Specify)  low injury occurred
ion	uttending death. ctor; Aft y the fun	atio	1 Matural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 □ Yes 2 □ No	
Division of Vital Records,	or Attending after death. Director; After in by the fune	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office 281. Location (S City or Tow	treet and Number or Rural Route Number, m, State)
	To the Hospitel or Attentwithin 24 hours after deatl To the Funerel Director: completely filled in by the	edicai C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, and due to the convestigation, in my opinion, death occurred at the time, of	cause(s) and manner as stated. date and place, and due to the cause(s)
	To the within 2 To the comple	Me		29c. License number	29d. Date signed (Month, Day, Year)
			) (3(1) mD	D 28035	03/27/06
0	P. I		30. Name and address of person who completed cause of death (Item 23a) (Typ BASIR MONTH PROPERTY AND THE CONTRACTOR OF T	a, Print) M.D. 9135 Piscer	taway Rd. # 310
	) b b Sta	to	31. Date filed (Month, Day, Year) 32. Paristrar's Signature	CLIN	70 N, MD 20735
	Registi		31. Date filed (Month, Day, Year) MAR 2 8 2006 32. Projectrar's Signature	Spack &	

			1 - For State Registrar	State of Maryland			of Health and of Death	-	giene Reg. No.	106	11255
	Dhysiai		1. Decedent's Name (First, Middle, Last	,				2. Date of De. Month	ath Day	Year	3. Time of Death
	Physici /Medic		JEFFREY	L.	-		INKEL		26,	2006	
	Examin	er	4a. Facility Name (If not institution, give The Johns Ho	pkins Hos	pital	Bo	own, or Location of Deat			ounty of Deat	
	Funeral Director		217 30 7702 .	7. Age (In yrs. I		Months	Year If Under 24 Hrs Days Hours Min.		<sup>h</sup> 24 <b>,1</b> 9	9. Birt Co 50 Mar	hplece (State or Foreign junitry) yland
	Maryland -f show	tor	Usual Residence of Decedent  10a. State  Maryland Howard		, Town or Loo umbia	cation					10d. Inside City Limits 1 ☐ Yes 2 No
	h with the	al Director	10e. Street and Number 6105 Tamar Drive			10f. Zip	2104.	5		ed Sta	
036	should be filed within 72 hours after death with the Maryland Mohalel Hyglene. marked other than "naturel" or liems 23a or 28a-f show marked seent, the Medical Examiner main be notified at	by Funeral	11. Marital Status  1 Never Married 2 Warried  3 Widowed 4 Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If	Vas Decede Yes, speci	ent of Hispanic Origin? (S fy Cuban, Mexican, Puer No Specify:	Specify Yes or No to Rican, etc.)		Black, White Brecify: W	
21215-003	within 72 ho ene. than "natur na Medical	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)		(Give I life. D	kind of worl OO NOT use	Occupation of done during most of wo retired)  ducation Tea		Balt	imore ol Dis	City
ō	Hygi other snt, I	0	17. Father's Name (First, Middle, Last) Jules		Fink			me (First, Middle,		umame)	dolph
, Mary	permit. Pages 1 and 2 should be Department of Health and Menta Important: If term 27 is marked eny Injury or other traumatic evone.		19a. Informant's Name/Relationship (7) Hillary Finkel -wi			-	Street and Number or R Drive Colum		-		
altimore,	Pages 1 and of He Int. If Item Inty or other		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □ 1  4 □ Donation 5 □ Other (Specify,	Removal from State	lace of Disposemetery, crem Lington	natory or oti	her place)	Date Lzuk 3/2		ation - City or 6 Balt	Town, State imore, Maryla
Balti	permit. Departn Importa eny Inje		21. Signature of Funeral Service Licens  Donald VI	3 - gwant	Dor 44(	nald 00 Por	Address of Facility Borgward  Wder Mill Ro	t Funera pad Belts	l Hom svill	e, PA e, Mar	yland 20705
)	Physician /Medical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lication that caused the death ne cause on each line. a. ARRHYTHM Due to (or as a consequ	IA	er the mode	of dying, such as cardia	c or respiratory a	rest,		Approximate Interval Between Onset and Death  DAYS
	physicien and UNITY IN Surial - Iransit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence.  Due to (or as a consequence.	uence of):	2c i Non	na of Hea	D AND	NECE	۷.	2 YEARS
.O. Box 68	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Ectopic pre			23	d. Date of del Month	ivery Day Year		
٦.	signed be de	ρ	Part II. Other significant conditions co	ntnbuting to death but not resu	ulting in the un	nderlying ca	use given in Part I.		obacco use		the cause of death?
al Records,	The ste h	Completed						1 Tes	rmed? 20 No	prior to death?	atopsy findings available completion of cause of 2□ No
Ž		o Be	25. Was case referred to medical examiner?	Hospital:	ED/Out-ati-	• • • • • • • • • • • • • • • • • • • •	Others	ath (Check only o		T015 - 102-2	-7.
on of	ling Afte	tlon: To	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury		Bc. Injury at Work?  1 Yes 2 No	dome 5 Resident			ciry
=	al or Attending s after death. il Director: After id in by the tune	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, stre			28f. Location ( City or Tox		Number or Ru	ural Route Number,
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical C	29a. Certifier (Check only one)	sician: To the best of my know iner: On the basis of examinat and manner stated.	wledge death tion and/or inv	vestigation,	t the time date and stan in my opinion, death occ	a and due to the urred at the time,	nause(s) a date and p	nd menner as lace, and due	stated to the cause(s)
	Withiu To the	Σ	29b. Signature and title of certifier			- 1	License number			signed (Monti	•
,	12		30. Name and address of person who c	MD ompleted cause of death (Item	23a) (Tyne 1	Print)	58902		MARCH	1 26,	2006
_			DAVID WAYE MO , J	HONS HOPKINS H	HSPITAL	, 600	NORTH WOLFE	STREET,	BALTIN	tope, M	AYCANO 21287
	Sta Registr		31. Date filed (Month, Day, Year)		ture	( )		•			

wa			For State Registrar		State o	f Marylar		artment rtificate			nd Me		giene Rag No.	005	112	56
	Physici		Decedent's Name (First, Donna L	Middle, Las ee		'itzpatı	rick					2. Date of Dea Month March	Day	Year 2006	3. Time (	
1	/Medio Examir		4a. Facility Name (If not inst		street and nur	mber)		4b. City, T		ocation of				County of Deat		
×.	Funeral Director		5. Social Security Number 216-40-6888	6. Se	M 2 XF	7. Age (In yrs. 62	last birthday) Yrs.	If Under 1	Year	If Under 2 Hours	4 Hrs. 8	B. Date of Birt (Month, Da an 25	h y, Year)		hplace (State	or Foreign
	the Maryland 28a-f show cutted at	ector	Usual Residence of Deceder   10a. State		k		ty, Town or Lo		Codo				10a Citiz	en of What Co		City Limils s 2√∑ No
	23a or 2	Funeral Director	107 Adams W	ay				217	93					USA		
036	be filed within 72 hours after death with the Maryland stal Hygiene. ad other than "natural", or Items 23a or 28a-1 show event, the Medical Examinar must be notified at	by	11. Marital Status  1 Never Married 2  3 Widowed 4 15 Div		12. Was Dece Armed Fo 1 Tyes If Yes, Giv Year or D	/8		Was Decede If Yes, specifi 1 Tes 2		anic Origi Mexican, Specify:	in? (Spec Puerto R	ify Yes or No ican, etc.)	- 1	4. Race - Ame Black, Whit Specify: Whi	e, etc.	
21215-0036	e filed within 72 ho al Hygiene I other than "natur vent, the Medical	Completed	15. Dec (Specify only) Elementary/Secondary (0 12	-		-4or 5+)	(Give	dent's Usual kind of work DO NOT use nts Re	k done du e retired)	ring most				ersity		ryland
Maryland 2	should be filed ind Mental Hygi marked other umatic event, I	To Be C	17. Father's Name (First, M. James R. La						1			First, Middle,				
Mar	is 1 and 2 should of Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relation Sean D. Fitz											Town, State, 2		
Baltimore,			20a. Method of Disposition  12 Burial 2 Crema 4 Donation 5 Ott	ation 3 🗆	Removal from	20b.	Place of Dispondentery, crestee of Heat	osition (Name matory or oth	e of her place)	I.	Da March	te	20c. Loc	er Spri	Town, State	ryland
Balt	permit. Page Department of Important: If sny injury of once.		21. Signature of Funeral Se	rvice Licen:	J 13.	yl	Fi	Name and Cancis 00 Uni	Address vers	collin ity E	ns F Blvd,	uneral	Hom			
4	Physician /Medical Examiner	her	23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate the product of the conditions of t	List only o	Ather a. Due to	aused the dea ach line. COSCLETO (or as a consect or as a consect	otic Ca		, .				rrest,		Approxim Intervat B Onset and Minute	etween d Death
8760,	icate be executed physician and the burial-transit	lical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1	c. Due to	(or as a consec	quence of):									
.O. Box 6	iaw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 □ Yes 2 ☒No 9 □ Unknown	FIL		ointh 2 ∏ Feta ant at time of	al death 3	Ectopic pre Other (spe					2	23d. Date of de Month	livery Day	Year
ecords, P.	w requires that been signed t should be det	þ	Part ff. Other significant co		_								Yes 2X	No 3 P	robably 4 [	Unknown
$\alpha$	The ate his page	e Completed	25. Was case referred to m	odical						oo Diasa	of Dooth	autor perfo	osy ormed? 2 No	prior to death?	utopsy finding completion of 2 No	cause of
ion of Vital	ng Phys fter this	To B	examiner? 1 ₺ Yes 2 □ No  27. Manner of Death 1 ₺ Natural 5 □ F	100	28a. Date (Mon	Inpatient 2 [ of Injury th, Day Year)	ER/Outpatie 28b. Time o Injury		Other Bc. Injury a Work?	4 □ Nur	sing Hom	(Check only only on the St. Resided Describe	ecify)			
Division	7 6 7 C	Certification:		Could not be letermined	280. Place	of Injury - At hing, etc. (Speci	nome, farm, st ify)	reet, factory,	office		2	8f. Location ( City or To		d Number or R )	urai Route Nu	mber,
	To the Hospital of within 24 hours at To the Funeral D completely filled i	dical	29a. Certifier 1 ☐ Ce (Check only 2 🛣 Me	rtifying Phy dical Exam	ysician: To the band man	best of my kn asis of examin nerstated.	owledge, deat ation and/or in	th occurred a evestigation,	it the time in my opi	, date and nion, deatl	d place, ar h occurre	nd due to the d at the time,	cause(s) date and	and manner a place, and du	s stated. e to the cause	o(s)
)		Me	29b. Signature and title of c	egrtifier E	2/4	lue	_llo	29c.	License D3	number 7197			29d. Date	e signed (Moni March	th, Day, Year,	
	10		30. Name and address of p Alan Rohre							rick,	. MD	21701				
	Sta Regist		31. Date filed (Month, Day,	Year)	2008 32.F	gistrar's Sign	ature /	park	9							

(b) Amended #23a(a), nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 03/30/06, Allegany Co. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2006 8:09 P 03 28 Philomena Rose Fabbri /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frostburg, MD
Under 1 Year | If Under 24 Hrs. | Allegany St. Vincent DePaul Nursing Center Date of Birth (Month, Day, Ye 27-Feb-19 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 21 F Days Hours Yrs. Maryland Director 214-07-3760 Usual Residence of Decedent within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County wohe! Itam 27 is marked other than "natural", or Items 23s or 28s-f shov other treumatic avent, the Modical Examinar must be notified at 1 Yes 2 □ No Director Frostburg Maryland Allegany 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 144 McCulloh Street U.S.A 21532-Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give ∫ Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If I tam 27 I a marked other than "nrang page. Elementary/Secondary (0-12) College (1-4or 5+) homemaker homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Rose Morelli ဂ္ Antonio Miglio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 11113 Broken Mine 21532 Frostburg Maryland Mike Fabbri son 20b. Place KOBOsitiOn Wame of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) ↑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 31-Mar-2006 Frostburg Maryland Saint Michael's Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 onn Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death sheck, or heart failu Immediate Cause (Final disease or condition Physician 1 Week URemIA resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, 1 any leading to minadial cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed the ettending physicien and hed for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐Ectopic pregnancy Month Day Year 5 Other (specify) signed by the e 1 ☐ Yes 2 1 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 Probably 4 ☐Unknown 1 Tes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performe certificete 2 No 1 ☐ Yes Division of Vital Hospital or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient Director: After this c 2 3 DDA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death 28b. Time of Certification: 5 Pending 1 Matural efter death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) efter. 4 ☐ Homicide To the Hospital
within 24 hours e
To the Funarel E completely filled To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANTE SATURNINA Brondway

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAR 3 0 2006

32. Pegistrar's Signature

		For	State of Marylan				Mental Hy	giene	100	11259
		State Registrar		Ce	rtificate of	Death		Reg. No.	U	11500
		1. Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day	Year	3. Time of Deat
Physici /Medic		Harry E	Freez	10			March		2006_	12:48 A
Examin		4e. Facility Name (If not institution, give s			4b. City, Town, o	r Location of De	eath	4c. County	of Death	
		College View Center	כ		Frederi	ck		Fred	leric	
Funeral		5. Social Security Number 6. Sex		last birthday)	Months Days		in. 8. Date of Bir (Month, Da	th ly, Year)	9. Birthp	plece (State or Fore
Director		219-66-3588	XM 2□F 48	8 Yrs.			July 1	1957	Penn	sylvania
11.00		Usual Residence of Decedent  10a. State 10b. County	10a Cit	y, Town or Lo					Т.	Od. Inside City Lin
, how	_									1 Tes 2
	cto	Maryland Frederic	ck T	hurmon			<del>-</del> -			X
nd Mental Hygiene marked other than "natural", or items 23a or 28a-f show imetic event, the Medical Examiner must be notified at	Director	10e. Street and Number	_		10f. Zip Code	_		10g. Citizen of		ntry?
23	100	36 East Moser Road			2178				S.A.	
SE E	by Funeral		12. Was Decedent Ever in U. Amed Forces?	.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? an, Mexican, Pu	(Specify Yes or No Jerto Rican, etc.)	Bla	ck, White,	can Indian, etc.
o E	y F.	Never Married 2 Married	1 XYes 2 ☐ No If Yes, Give		1 ☐ Yes 2 🗓 No	Specify:		Specil		
ural.	q p	3 Widowed 4 Divorced	Year or Dates:	10 P	4 - 4 - 11 - 10 -			10h Kind of E	Whi	
net	Completed	15. Decedent's Edu (Specify only highest grade	cation s completed)	16a. Dece (Giv€	edent's Usual Occup e kind of work done DO NOT use retire	during most of	working	16b. Kind of B	usiness/in	dustry
Pan A	mp	Elementary/Secondary (0-12)	College (1-4or 5+)					D .		_
her t	ပိ	17. Father's Name (First, Middle, Last)		Res	taurant M		Name (First, Middle	Resta Maiden Sumai		
d of	Be	Warren Freeze					Fraley		,	
Merk	2		(D-'-4)	10h Mail	ing Address (Street		Rural Route Numb	or City or Tour	State 7ie	Codel
Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic events.	1	19a. Informant's Name/Relationship (Ty Joan Freeze/Aunt	pe, Print)				Thurmont,			7 (1008)
m 27 m 27 her t		<u> </u>	20b F				Date	20c. Location		own State
or of		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ P	temoval from State		osition (Name of amatory or other pla				-	
ant:		*4 □ Donation 5 □ Other (Specify)	Smi		rg Cremat					Marylan
Depart Import any inj		21. Signature of Funeral Service Licens	99	$R^2$	2. Name and Addre	ss of Facility DAILEY	& SON FUN	IERAL HO	MES.	P.A.
ro = = g		TANE	ELIT .	16	15 EAST M	AIN STR	EET, THUE	RMONT. M	D 21	788
ysicien and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence)  Due to (or as a consequence)							
	//Medical		d							
by the atter	hysiciar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	ıl death 3 (	□Ectopic pregnanc	y			ate of deliv	ery Day Year
by the atter	ed by Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3 ( death 5 (	Other (specify)		23e. Did	tobacco use con	onth stribute to t	Day Year
has been signed by the atter		23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9  Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3 ( death 5 (	Other (specify)		24a. Was	tobacco use con Yes 2 No an 24b.	onth  atribute to t  3 Prof  Were autoprior to co death?	he cause of death bably 4 Unkn opsy findings avai ampletion of cause
ate has been signed by the atterpage 2 should be detached for i	Completed	23b. Was decedent pregnant in the past 12 months? 1 \( \text{ Yes} \) 2 \( \text{No} \) 9 \( \text{Unknown} \)  Part II. Other significant conditions con	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3 ( death 5 (	Other (specify)	ven in Part I.	24a. Was	Modern Mo	atribute to t	he cause of death bably 4 Unkn opsy findings avai ampletion of cause
ate has been signed by the atter page 2 should be detached for t	Be Completed	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  Part II. Other significant conditions condition	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown  Intributing to death but not res	al death 3 (	Other (specify) _	ven in Part I.	24a. Was auto perfit 1 Yes	Yes 2 No 24b. pry 2 No 2000	were autoprior to codeath?	he cause of death bably 4 Unknoppsy findings available in or cause 2 No
ate has been signed by the page 2 should be detached	To Be Completed	23b. Was decedent pregnant in the past 12 months?  1	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown  Intributing to death but not res	al death 3 (leath 5 (	Other (specify) underlying cause grant 3 DOA Other	zen in Part I.  26. Place of	24a. Was auto perfet 1 Test Perfet Pe	Montobacco use con Yes 2 No 24b. psy 2 No 2000000000000000000000000000000000	were autoprior to codeath?	he cause of death bably 4 Unkroppy findings available in of cause 2 No
ate has been signed by the page 2 should be detached	To Be Completed	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions cond	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown  Intributing to death but not res	al death 3 (	Other (specify) underlying cause grain all DOA Other (specify) ent 3 DOA Other (specify) of 28c. Injury Wo	26. Place of ner:	24a. Was auto perfet 1 Test Perfet Pe	Yes 2 No 24b. pry 2 No 2000	were autoprior to codeath?	he cause of death bably 4 Unkroppy findings available in of cause 2 No
ate has been signed by the atter page 2 should be detached for t	To Be Completed	23b. Was decedent pregnant in the past 12 months?  1	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown  ntributing to death but not res  Hospital: 1 Inpatient 2 2	al death 3 (seath 5 (	Other (specify) underlying cause grant 3 □ DOA Other of 28c. Inju Mo M 1 □	26. Place of	24a. Was auto perfet   1   Yes   Death (Check only of Home   5   Resi   28d. Describe   28f. Location (	tobacco use con Yes 2 No is an 24b. pry prmed2 2 No one) idence 6 Ot how injury occu	onth  3   Proi  Were autoprior to code autoprior to code autoprior to code autoprior to code autoprior code aut	he cause of death bably 4 Unknoppsy findings available and 2 No
ate has been signed by the atter page 2 should be detached for t	Certification: To Be Completed	23b. Was decedent pregnant in the past 12 months?  1	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown  Intributing to death but not res  Hospital: 1 Inpatient 2 2  28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At h building, etc. (Special sician: To the best of my known on the basis of examine.	al death 3 (death 5 (	ont 3 DOA Ottor (specify)	26. Place of ner: A varsir ry at rk? Yes 2 \( \sum \) No	24a. Was auto pentil 1 Yes  Death (Check only ag Home 5 Resi 28d. Describe  28f. Location (City or To	Montobacco use con Yes 2 No 24b. 22 No 24b. 24b. 24b. 24b. 24b. 24b. 24b. 24b.	onth  3 Proi  Were autoprior to codeath? 1 Yes  ther (Special perior or Runner as sanner Day Year the cause of death bably 4 Unkn oppy findings avail mpletion of cause 2 No fy) al Route Number,	
24 hours after death. Funeral Director: After this certificate has been signed by the atter stely filled in by the funeral director, page 2 should be detached for i	edical Certification; To Be Completed	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions cond	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown  Intributing to death but not res  Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At houlding, etc. (Special sician: To the best of my knoth sician sician sician sician sician sician sician sic	al death 3 (death 5 (	ont 3 DOA Ottor (specify)	26. Place of ner: 4 Nursin ry at rk? Yes 2 No	24a. Was auto pentil 1 Yes  Death (Check only ag Home 5 Resi 28d. Describe  28f. Location (City or To	Montobacco use con Yes 2 No 24b. 22 No 24b. 24b. 24b. 24b. 24b. 24b. 24b. 24b.	were autoprior to codeath?  The codeath?  The codeath?  The codeath?  The codeath?  The codeath?  The codeath?  The codeath?  The codeath?  The codeath?  The codeath?  The codeath?  The codeath?  The codeath?  The codeath?	Day Year the cause of death bably 4 Unknot poppy findings avails ampletion of cause 2 No fy) al Route Number, stated, o the cause(s)
24 hours affer death. Funeral Director: After this certificate has been signed by the attensieny filled in by the funeral director, page 2 should be detached for a	Certification: To Be Completed	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions cond	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown  Intributing to death but not res  Hospital: 1 Inpatient 2 2  28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At h building, etc. (Special sician: To the best of my known on the basis of examine.	al death 3 (death 5 (	ont 3 DOA Ottor (specify)	26. Place of oner:  yen in Part I.  26. Place of oner:  y at rk?  Yes 2 \( \sum \) No  me, date and popinion, death of see number	24a. Was auto performed at the time,	Yes 2 No  Yes 2 No  I an psy promed 2 24b.  John 2 24b.  John 3 24b.  John 3 24b.  John 3 24b.  John 4 24b.  John 4 24b.  John 5 24b.  John 4 24b.  John 5 24b.  John 5 24b.  John 6 1 Other 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	were autoprior to codeath?  1 Yes  Therefore autoprior to codeath?  1 Yes  Therefore autoprior to codeath?  1 Yes  Therefore autoprior to codeath?  Therefore autoprior to codeath?  Therefore autoprior to codeath?  Therefore autoprior to codeath?  Therefore autoprior to codeath?	Day Year  the cause of death bably 4 Unkn  popy findings avail completion of cause 2 No  fy)  al Route Number,  stated. o the cause(s)  Day, Year)
ate has been signed by the atterpage 2 should be detached for i	edical Certification; To Be Completed	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions cond	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown  Intributing to death but not res  Hospital: 1 Inpatient 2 2 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - At h building, etc. (Special sician: To the best of my known and manner stated.	BER/Outpatie  28b. Time of Injury  ome, farm, story)	ont 3 DOA Ottor (specify)	26. Place of oner:  yen in Part I.  26. Place of oner:  y at rk?  Yes 2 \( \sum \) No  me, date and popinion, death of see number	24a. Was auto performed at the time,	Yes 2 No  Yes 2 No  I an psy promed 2 24b.  John 2 24b.  John 3 24b.  John 3 24b.  John 4 24b.  John 4 24b.  John 5 24b.  John 5 24b.  John 6 1 Other 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	were autoprior to codeath?  1 Yes  Therefore autoprior to codeath?  1 Yes  Therefore autoprior to codeath?  1 Yes  Therefore autoprior to codeath?  Therefore autoprior to codeath?  Therefore autoprior to codeath?  Therefore autoprior to codeath?  Therefore autoprior to codeath?	Day Year  the cause of death bably 4 Unkn  popy findings avail completion of cause 2 No  fy)  al Route Number,  stated. o the cause(s)  Day, Year)
At hours after death. Funeral Director: After this certificate has been signed by the attention filled in by the funeral director, page 2 should be detached for its process.	edical Certification; To Be Completed	23b. Was decedent pregnant in the past 12 months?  1   Yes 2   No 9   Unknown  Part II. Other significant conditions cond	1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown  Intributing to death but not res  Hospital: 1 Inpatient 2 Eas. Date of Injury (Month, Day Year)  28a. Place of Injury - At h building, etc. (Special of the basis of examina and manner stated.	BER/Outpatie  28b. Time of Injury  ome, farm, story)	ont 3 DOA Ottor (specify)	26. Place of oner:  yen in Part I.  26. Place of oner:  y at rk?  Yes 2 \( \sum \) No  me, date and popinion, death of see number	24a. Was auto pentil 1 Yes  Death (Check only ag Home 5 Resi 28d. Describe  28f. Location (City or To	Yes 2 No  Yes 2 No  I an psy promed 2 24b.  John 2 24b.  John 3 24b.  John 3 24b.  John 4 24b.  John 4 24b.  John 5 24b.  John 5 24b.  John 6 1 Other 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	were autoprior to codeath?  1 Yes  Therefore autoprior to codeath?  1 Yes  Therefore autoprior to codeath?  1 Yes  Therefore autoprior to codeath?  Therefore autoprior to codeath?  Therefore autoprior to codeath?  Therefore autoprior to codeath?  Therefore autoprior to codeath?	Day Year  the cause of death bably 4 Unkn  popsy findings avail completion of cause 2 No  fy)  al Route Number,  stated. o the cause(s)  Day, Year)

Dhusisi		1- For State Registrar			Certifi	cate or	Death		Reg	No. 🚄 U U	6 1 25
Physici al Exami		Decedent's Name (Fig. 1)	irst, Middle,La	Perci	val Fer	al			2. Date of Death Month D April 2, 2006	ay Year	3. Time of Death 10:40PM
		4a Facility Name (if not Washington Co	· -		per)	4	b. City, Town, or L Hagerstown	ocation of Death		4c. County of De Washington	
Funeral Director		5. Social Security Numb			Age (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth(	MM/DD/YYYY) 9.	Birthplace (State or Foreigr Country) Aaryland
ý.		Usual Residence of Dec	cedent c. County		10c. City, Tow	vn or Locatio	on				10d. Inside City Limits
Maryland 28a-f show any d at once.	_		-	ngton Co	. Hage	ersto	wn				1 XYes 2 No
arylar 8a-f s at on	Director	10e. Street and Number					10f. Zip Code		10g.	Citizen of What (	Country?
the M a or 2 lifted	Öire	69 Broad	wav.	Apt. B			217	740		USA	
ath with items 23: ust be not	Funeral	11. Marital Status  1 Never Married		12. Was Deced	lent Ever in U.S. es?		s Decedent of Hisp es, specify Cuban,			White, et	
fter d I", or ner m		3 Widowed	4 Divorc	ced If Yes, Give Year or Dates:	2	1	Yes 2 X No	specify:		Specify:	white
tours a	d b	15. Decedent's Educa		only highest grade	duri	ing	's Usual Occupation		vork done 1	3b. Kind of Busine	ess/Industry
n 72 h nan "n ical E	olete	Elementary/Seconda	ary (0-12)	College (1-4	or 5+)	most of v	vorking life. DO NO		2.10	Λ11± ~~	notive
giene. her th	Completed by	11 17. Father's Name (Firs	st Middle I a	ast)		Auto	Body I		.an (First, Middle, Ma		IIO LI VE
al Hyg	a			Lee Mor	rison.	Jr.			trice E		omew
Ment Mark mark	9 B	19a. Informant's Name/			T T DOIL /		Address (Street		Rural Route Number		
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.			Other Special Service Lice and Service and Service Lice and Service Lice and Service Lice and Service Lice and Service Lice and Service Lice and Service and Service Lice and Service Lice and Service Lice and Service and Service Lice and Service and	censee  multiplications that cau heach line.	Smith	22. N 1 2 not enter th	ame and Address	of Facility J. adburv	L. Dav Avenue	is Fund Smiths	sburg, MD eral Home burg, MD 21 Approximate Interval 8etween Onset and Death
hysician /Medical		21. Signature of Funera  23. Purp. Enter the difailure. List only o Immediate Cause (Fine or condition resulting ir Sequentially list condit if any, leading to imme cause. Enter Underlyir	Other Special Service Lice Serv	censee  mplications that cau	Smith used the death. Do intoxicat consequence of):	22. N 1 2 not enter th	g Crema ame and Address	of Facility J. adburv	L. Dav Avenue	is Fund Smiths	eral Home burg, MD 21 Approximate Interval 8etween Onset and
hysician /Medical Examiner	Examiner	21. Signature of Funera 28.4 Pyrn. Enter the di failure. List only o Immediate Cause (Fina or condition resulting in Sequentially list condit if any, leading to imme-	Other Special Service Lical Se	city: consee complications that cau each line. a. Narcotic Due to (or as a c	Smith used the death. Do intoxicat consequence of):	22. N 1 2 not enter th	g Crema ame and Address	of Facility J. adburv	L. Dav Avenue	is Fund Smiths	eral Home burg, MD 21 Approximate Interval 8etween Onset and
hysician /Medical Examiner	Examiner	21. Signature of Funera  28a Pyrth. Enter the di failure. List only o Immediate Cause (Fina or condition resulting ir  Sequentially list condit if any, leading to imme cause. Enter Underlyit (Disease or injury that events resulting in dea	Other Special Service Lical Se	prince to the country of the country	Smith used the death. Do intoxicat onsequence of): onsequence of):	22. N 12 not enter th	rg Crema lame and Address 2525 Bra ne mode of dying,	of Facility J.adbury	L. Dav Avenue or respiratory arrest	is Fund Smiths	eral Home burg, MD 21 Approximate Interval 8etween Onset and
hysician /Medical examiner	Examiner	21. Signature of Funera  28a Pyrth. Enter the di failure. List only o Immediate Cause (Fina or condition resulting ir  Sequentially list condit if any, leading to imme cause. Enter Underlyit (Disease or injury that events resulting in dea	Other Special Service Lice Serv	city: censee  mplications that cau a each line.  a. Narcotic Due to (or as a c c. Due to (or as a c d.  X AMENDED  23c. If yes, ou 1 Live bir 4 Pregna	sed the death. Do intoxicat onsequence of): onsequence of): item#1,23a utcome of pregnan th nt at time of death	22. N 1 2 2 not enter the cion 1,27,28a	rg Crema lame and Address 2525 Bra ne mode of dying,	of Facility J.adbury	L. Dav Avenue or respiratory arrest	is Fund Smiths	eral Home burg, MD 21 Approximate Interval 8etween Onset and Death
hysician /Medical examiner	Examiner	21. Signature of Funera  Bat Pyrth. Enter the difailure. List only of Immediate Cause (Fina or condition resulting in Sequentially list conditificancy, leading to Immediate. Enter Underlyin (Disease or injury that events resulting in deal VIV)  UNPENDED  IF FEMALE: 23b. Was decedent prepast 12 months?	Other Special Service Lice Serv	city: censee  mplications that cau a each line. a. Narcotic Due to (or as a c c. Due to (or as a c d.  AMENDED  23c. If yes, ou 1 Live bir 4 Pregna 9 Unknown 9 Unknown	smith used the death. Do intoxicat onsequence of): onsequence of): item#1,23a utcome of pregnan th nt at time of death vn	22. N 1 2 2 n not enter the cion 1,27,28a 1,27,28a 1 5 0 ot	rg Crema ame and Address 2525 Bra he mode of dying, s a—f,perME,g tal death 3 [ her (Specify)	of Facility J.  adbury such as cardiac of	L. Dav Avenue or respiratory arrest	ris Fune Smiths! , shock, or heart 23d. Date of del Month	eral Home burg, MD 21 Approximate Interval 8etween Onset and Death
hysician /Medical xaminer	Examiner	21. Signature of Funera  Big Pirit. Enter the difailure. List only of Immediate Cause (Fina or condition resulting in Sequentially list condition if any, leading to immediate. Enter Underlyin (Disease or injury that events resulting in deal WINDED IF FEMALE: 23b. Was decedent prepast 12 months?  1 Yes 2 No. 9  Part II. Other significations and sequential sequen	Other Special Service Lice Serv	city: censee  mplications that cau a each line. a. Narcotic Due to (or as a c c. Due to (or as a c d.  AMENDED  23c. If yes, ou 1 Live bir 4 Pregna 9 Unknown 9 Unknown	smith used the death. Do intoxicat onsequence of): onsequence of): item#1,23a utcome of pregnan th nt at time of death vn	22. N 1 2 2 n not enter the cion 1,27,28a 1,27,28a 1 5 0 ot	rg Crema ame and Address 2525 Bra he mode of dying, s a—f,perME,g tal death 3 [ her (Specify)	of Facility J.  adbury such as cardiac of	L. Dav Avenue or respiratory arrest  O6 TT  ancy  23e. Did tob. 1 Yes	23d. Date of del Month	eral Home burg, MD 21 Approximate Interval 8etween Onset and Death  livery Day Year  te to the cause of death? Probably 4 Unknown
hysician /Medical xaminer	Examiner	21. Signature of Funera  Big Pirit. Enter the difailure. List only of Immediate Cause (Fina or condition resulting in Sequentially list condition if any, leading to immediate. Enter Underlyin (Disease or injury that events resulting in deal WINDED IF FEMALE: 23b. Was decedent prepast 12 months?  1 Yes 2 No. 9  Part II. Other significations and sequential sequen	Other Special Service Lice Serv	city: censee  mplications that cau a each line. a. Narcotic Due to (or as a c c. Due to (or as a c d.  AMENDED  23c. If yes, ou 1 Live bir 4 Pregna 9 Unknown 9 Unknown	smith used the death. Do intoxicat onsequence of): onsequence of): item#1,23a utcome of pregnan th nt at time of death vn	22. N 1 2 2 n not enter the cion 1,27,28a 1,27,28a 1 5 0 ot	rg Crema ame and Address 2525 Bra he mode of dying, s a—f,perME,g tal death 3 [ her (Specify)	of Facility J.  adbury such as cardiac of	L. Dav Avenue r respiratory arrest  Of TT  ancy	23d. Date of del Month  22 No 3 24b. Were priored?	eral Home burg, MD 21 Approximate Interval 8etween Onset and Death  livery Day Year  te to the cause of death? Probably 4  Unknown re autopsy findings available to completion of cause of
hysician /Medical xaminer	Examiner	21. Signature of Funera  28. Pyri. Enter the difailure. List only of Immediate Cause (Fina or condition resulting in Sequentially list condition if any, leading to immediate. Enter Underlyin (Disease or injury that events resulting in deal VINPENDED  IF FEMALE: 23b. Was decedent prepast 12 months?  1 Yes 2 No. 9  Part II. Other significations are supported in the significant in the signific	Other Special Service Lice Serv	mplications that cau each line. a. Narcotic Due to (or as a c c. Due to (or as a c d.  X AMENDED  23c. If yes, ou 1 Live bir 4 Pregna own 9 Unknowns contributing to	smith used the death. Do intoxicat consequence of): consequence of): item#1,23a utcome of pregnan th nt at time of death wn death but not resu	22. N 1 2 2 o not enter the cion  1,27,28a  1,27,28a  1,27 o other than 1 of the cion  2	rg Crema ame and Address 2525 Branch and Provided Address 2525 Branch and Provided Address are mode of dying, standard and address are f, perME, go stal death 3 [ her (Specify) underlying cause go	of Facility J.  adbury such as cardiac of  2854,4/17/  Ectopic pregn	L. Dav Avenue  r respiratory arrest  06 TT  ancy  23e. Did tob: 1	23d. Date of del Month  2 No 3 24b. Were priored? No 1 V	Approximate Interval 8etween Onset and Death  livery Day Year  te to the cause of death? Probably 4 Unknown re autopsy findings available to completion of cause of th? Yes 2 No
hysician /Medical xaminer	Examiner	21. Signature of Funeral PM. Enter the difailure. List only of Immediate Cause (Fina or condition resulting in Sequentially list condition if any, leading to immediate. Enter Underlying (Disease or injury that events resulting in deal VINDENDED IF FEMALE: 23b. Was decedent prepast 12 months?  1 Yes 2 No. 9  Part ii. Other significations.	Other Special Service Lice Serv	city: censee  Parity: censee  Parity: censee  Parity: censee  A Narcotic Due to (or as a cook Due to (or as a cook A AMENDED  23c. If yes, ou 1 Live bir 4 Pregna Down 9 Unknowns contributing to	smith used the death. Do intoxicat consequence of): consequence of): consequence of): item#1,23a autome of pregnanth that at time of death windeath but not result patient 2  EF	22. N 1 2 2 not enter the cion  1,27,286 1 5 0t  Control of the co	rg Crema lame and Address 2525 Bra lame mode of dying, see mode of dying, see mode of dying, see mode of dying, see mode of dying, see mode of dying, see mode of dying, see mode of dying, see mode of dying, see mode of dying, see mode of dying, see mode of dying, see mode of dying cause of the dyi	of Facility J.  adbury such as cardiac of  g854,4/17/  Ectopic pregn  given in Part I.	L. Dav Avenue r respiratory arrest  Of TT  ancy  23e. Did tob. 1 Yes  24a. Was ar autopsy perform 1 Yes 2  only one) ng Home 5 R	23d. Date of dei Month  2 No 3  24b. Wer prio dea No 1  esidence 6	Approximate Interval 8etween Onset and Death  livery Day Year  te to the cause of death? Probably 4 Unknown re autopsy findings available to completion of cause of th? Yes 2 No
hysician /Medical xaminer	Examiner	21. Signature of Funeral PM. Enter the difailure. List only of Immediate Cause (Fina or condition resulting in Sequentially list condition if any, leading to immediate. Enter Underlying (Disease or injury that events resulting in deal VINDENDED IF FEMALE: 23b. Was decedent prepast 12 months?  1 Yes 2 No. 9  Part ii. Other significations.	Other Special Service Lice Serv	mplications that cau a cach line.  a. Narcotic Due to (or as a cach b. Due to (or as a cach d.  Zac. If yes, or Live bir Pregna Own Unknowns Contributing to the	smith sed the death. Do intoxicat onsequence of): onsequence of): item#1,23a atcome of pregnan th int at time of death on death but not resu  patient 2  Ef f Injury Day,Year) 28	22. N 1 2 2 not enter the cion 1,27,28a acy 2 Fe 1 5 ot Elting in the constraint of	ame and Address 2525 Branch and Address 2525 Branch amode of dying, standard and address 2525 Branch a	of Facility J.  adbury such as cardiac of  a854,4/17/  Ectopic pregn  given in Part I.  e of Death (Check Other Work?	L. Dav  Avenue  r respiratory arrest  06 TT  ancy  23e. Did tob: 1  Yes 24a. Was ar autops; perform 1 Yes 2 only one) ng Home 5 R 28d. Describe ho	23d. Date of del Month  2 No 3 24b. Were priored? No 1 V	Approximate Interval 8etween Onset and Death  livery Day Year  te to the cause of death? Probably 4 Unknown re autopsy findings available to completion of cause of th? Yes 2 No
at the death certificate be executed  A by the attending physician and tached for use as the burial - transit	Examiner	21. Signature of Funeral PM. Enter the difailure. List only of Immediate Cause (Fina or condition resulting in Sequentially list condition if any, leading to immediate. Enter Underlying (Disease or injury that events resulting in deal VINDENDED IF FEMALE: 23b. Was decedent prepast 12 months?  1 Yes 2 No. 9  Part ii. Other significations.	Other Special Service Lice Serv	mplications that cau each line.  a. Narcotic Due to (or as a c c. Due to (or as a c d.  X AMENDED  23c. If yes, ou 1 Live bir 4 Pregna own 9 Unknowns contributing to	smith sed the death. Do intoxicat onsequence of): onsequence of): item#1,23a atcome of pregnan th int at time of death on death but not resu  patient 2  Ef f Injury Day,Year) 28	22. N 1 2 2 not enter the cion  1,27,28a  1,27	rg Crema ame and Address 2525 Bra are mode of dying, s are mode of dying	of Facility J.  adbury such as cardiac of  BECtopic pregn given in Part I.  e of Death (Check Other4 Nursi ry at Work? Yes 2 X No	L. Dav  Avenue  respiratory arrest  23e. Did tob: 1	23d. Date of del Month  2 No 3 24b. Wer prio dea No 1 versidence 6 ver	Approximate Interval 8etween Onset and Death  livery Day Year  te to the cause of death? Probably 4 Unknown re autopsy findings available to completion of cause of th? Yes 2 No

State Registrar

30. Name and address of person who completed cause of death (Item 23a)



Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

O.C.M.E.

April 3, 2006

DHMH 17 Rev 1/2001 OCME 10/2003

			For State Registrar  1. Decedent's Name (First, Middle		f Marylar		artment rtificate			and M		Reg. No.	106	1 2 6 0
	Physicia /Medic Examin	al	Millicent Mayhew 4a. Facility Name (If not institution	Fisher	mber)				r Location o	f Death	March 2,	2008	Year County of Deal Calve	10:20 A м
	Funeral Director	, ville	425 Shortbow T 5. Social Security Number 028-10-2350	rail  6.Sex  1 M 2 RF	7. Age (In yrs. <b>94</b>	. last birthday) Yrs.	Lus  If Under  Months		If Under	24 Hrs. Min.	8. Date of Bi (Month, Da May 2	rth ay, Ye <i>ar)</i> 1911	9 Bin	hplace (State or Foreign buntry) sachusettes
Machand	-f ehow field at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Calver			ity, Town or Lo	ocation							10d. Inside City Limits 1 Tyes 🗷 No
تاریخ داریخ وط	23a or 28a ast be not	ai Director	10e. Street and Number 425 Shortbow T	rail			10f. Zip	Code 206	57			Uni	zen of What Co ted Sta	ites
5-0036	"natural", or iteme 23a or 28a-f ehow	by Funerai	11. Marital Status  1 Never Married 2 Marr  3X Widowed 4 Divorced	ned 1 ☐ Yes	2 <b>X</b> No ve		Was Deced If Yes, spec 1 ☐ Yes	ify Cuba	lispanic Ori an, Mexican Specify:	gin? (Sp i, Puerto	ecify Yes or No Rican, etc.)		Black, White Specify: Wh	te, etc.
121	(0)	Completed		nt's Education est grade completed)	1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us Dry in	rk done se retire	during mos d)	t of work	ing		nd of Business ufactur	ing plant
aryland 2	and Mental Hygiene. I smarked other than raumatic event, Ira M	To Be Co	17. Father's Name (First, Middle, Frederick May)						18. Mothe	ve C	e (First, Middle arlson			
	n 27 n 27 ier t		19a. Informant's Name/Relations Marjory Brownin			425 5	hortk	' WOX	Trail	Lus	by MD 2	20657	r Town, State,	
Baltimore,	thent or the side of the side		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation  4 □ Donation 5 □ Other (S  21. Signature of Funeral Service	Specify)	State Me	Place of Dispo cemetery, cre LTOPOLI	tan F					Alex	andria	Virginia
Ba	Depa impo eny ir		23a. Part1. Enter the disease, o	r complications that	caused the dea	44	105 Br	coom	es Is	. Rd	usch Fu Port  or respiratory	Repu		20676 Approximate Interval Between
	hysician /Medical Examiner		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Sep Due to UTI	osis (or as a conse									Onset and Death  1 day  few days
1760,	hysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	equence of):										
. Box 68	e attending pl	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 Live	itcome of pregi birth 2 TFe nant at time of lown	tal death 3	⊒Ectopic pi ⊒ Other (sp		у		77-2	4	23d. Date of de Month	olivery Day Year
rds, P.	5 5	ď	Part II. Other significant conditi	ions contributing to c	leath but not re	esulting in the u	underlying o	ause gr	ven in Part I			tobacco u		o the cause of death?  robably 4 Unknown
		Completed	Asthm	a							per	s an opsy formed? 2 <b>X</b> No	24b. Were a prior to death?	utopsy findings available completion of cause of s 2 □ No
Vital	rnysicien: In this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:				Ott	200		th (Check only		. 50 /6	
o d	After After fune	ation: To	1 ☐ Yes 2 ₩ No  27. Manner of Death  1 ※ Natural 5 ☐ Pendi 2 ☐ Accident invest	28a. Date	Inpatient 2[ of Injury oth, Day Year)	Z8b. Time of Injury		28c. Inju Wo	4[] NI		ome <b>5%</b> Res			ecny)
5	= 2 ± ± 0	i Certification:	4 El Homicide	mined 286. Flac	e of Injury - At ling, etc. (Spec	cify)			- dat-	ad els	City or T	own, State	) 	Rural Route Number,
	o the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check only 2 Medica one)		e best of my ki pasis of examinated.	nation and/or i	nvestigation	i, in my	opinion, dea	ath occu	, and due to the	a, date and	and manner a d place, and du te signed (Mor	e to the cause(s)
	Tor	2	29b. Signature and title of certifi					c. Licen	D 369	69			ch 2 20	
	/		30. Name and address of person  Scaria Mathe	w, MD 119	10 H.G.	Truem		ad,	Lusby	Mar	yland	20657	<u> </u>	
	Sta Regist		31. Date filed (Month, Day, Year	3 0 2005	Registr // s Sig	nature								

			· ·		siack indelible ink		•	3
			1 - For State Registrer	State of Maryland	d / Department of I Certificate of		4	.000 11601
			Hegistrer     Decedent's Name (First, Middle, Last)		Certificate of		Reg. No.	3. Time of Death
	ysicia Medic		Margaret	Harman	Finney		Month E	23 2006 12 28 M
7	kamin		4a. Facility Name on not institution, give s	i 1/	1 1	or Location of Death		c. County of Death
Fur	neral		5. Social Security Number 6. Sex	7. Age (In yrs. la	tal = C ast birthday) If Under 1 Year		. Date of Birth	9. Birthplace (State or Foreign
	ector		231-428075 10	M 200 F 70	Yrs. Months Days	Hours Min.	Date of Birth (Month, Day, Yea (Apt 21, 1	1935 Virginia
and	-		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Location		,	10d. Inside City Limits
5-0036 0 CCC 72 hours after death with the Maryland natural; or flema 23a or 28a-f show	event, the Medical Examinar must be notified at	ţo	MD Queen A	1	Frasonvil	10-		1 ☐ Yes 2 ☐ No
th the 0, 285	guot	irec	10e. Street and Number		10f. Zip Code		10g. (	Citizen of What Country?
ath w	Trant	Funeral Director	112 Whittica	Lane-P.O.Bo	x41 210	638		USA
fer de	Instru	une	11. Marital Status 1  1 □ Never Married 2 □ Married	<ol> <li>Was Decedent Ever in U.S Armed Forces?</li> <li>1 ☐ Yes 2 ☑ No</li> </ol>	S. 13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Speci an, Mexican, Puerto Ri	fy Yes or No- can, etc.)	14. Race - American Indian, Black, White, etc.
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. 77 is marked other than "natural", or	Exam	þ	3 ☐ Widowed 4 Drivorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No	Specify:		Specify: Black
72 hg	dicel	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	oation during most of working	16b.	Kind of Business/Industry
nd 2121 e filed within al Hygiene.	the Ms	ошо	Elementary/Secondary (0-12)	College (1-4or 5+)	Care P		/	Jun Home
de filed	/ent,	Be C	17. Father's Name (First, Middle, Last)		Care	18. Mother's Name (	First, Middle, Maide	
arylan should be nd Mental	atic e	ToB	Otha L	tarman		Sarah	Jane	Chandlier
Aar 2 sho	raum	1	19a. Informant's Name/Relationship (Typ	0.44	19b. Mailing Address (Street	and Number or Rural F	Route Number, City	
- 5 9 4	injury or other traumatic		Seorgia H.  20a. Method of Disposition	10/1and	ace of Disposition (Name of	us Circle	- L-/ Pa	Local on - City or Town, State
S 70 =	y or 0	ĺ	1 1 Burial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)	emoval from State	ometery, crematory or other pla 165 Fev Cemil	CB)	11/0	
Baltimore, permit. Pages 1 g Department of He Important: if Itam	y injur	}	21. Signature of Funeral Service License		22. Name and Addre	ess of Pacility		nester Maryland
<b>0</b> 88 E	any ir		Janelle C.	Henry	Henry 1	ningten	tome, re.	bridge MD. 21613
			23a. Part . Enter the disease, or complic shock, or heart failure. List only one	ations that caused the eath.	Do not enter the mode of dyi	ng, such is cardiac or r	espiratory arrest,	Approximate Interval Between Onset and Death
Physic /Med	_		Immediate Cause (Final disease or condition resulting in death)	Litoacis	2001			Onset and Death
Exam				Due to (or as a consequ	ale Human	glycemia		
		ner	Sequentially list conditions, any, leading to minimize a cause. Enter Underlying Cause (Disease or injury that initiated events	Olle lo (or as a conseque		giycemia		-
ecuted	transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Devere 1	Jehy dratio	٥٨		
760, e be executed sician and	burial	cai E		Morbid	ence of):			
68760, ificate be expensed by physician			d.	71101 01 0	0123119			
Box eath cert attendin	for use as	an/M	Lob. Was dooddon program	ic. If yes, outcome of pregnan	ncy death 3 Ectopic pregnanc	,		23d. Date of delivery
I Records, P.O. Box 68 The law requires that the death certifica ate has been signed by the attending ph	hed fo	Completed by Physician/Med	in the past 12 months? 1  Yes 2 No 9 Unknown	4☐Pregnant at time of dea 9☐ Unknown				Month Day Year
, P.O. that the d	detac	V Ph	Part II. Other significant conditions cont	ributing to death but not resul	Iting in the underlying cause given	en in Part I.	23e. Did tobacco	use contribute to the cause of death?
rds quires on sign	old blu	q pe	Uncontrolled H	ypertension			1 🗆 Yes	2 <b>@</b> No 3 ☐ Probably 4 ☐ Unknown
Records, he law requires to has been signed.	2 should	piet	Probable dill	use Ather	05010025		24a. Was an autopsy	24b. Were autopsy findings available
Vital Re	page	Com	DC.	,•			performed?	prior to completion of cause of death? In a prior to completion of cause of the death?
Vital	rector,	Be	25. Was case referred to medical examiner?	ospital:	R/Outpatient 3 DOA Off	26. Place of Death (C		
Phys	aral di	To	1 ☐ Yes 2 ☐ No  27. Manner of Death	28a. Date of Injury	TVOdipatient 3 BOA	4 Litarang Home	5 Residence  Describe how inj	6 ☐Other (Specify)
ion inding ath. r: Afte	e fune	atior	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	28b. Time of 28c. Injury World 1 □	k? Yes 2 □No	,	
Division of I or Attending Phy after death. Director: After this	n by th	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	me, farm, street, factory, office	28f	Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
pital c	pelli .		29a. Certifier 1 Certifying Physi	ofone To the best of muckness	dodos dosta	data and along		
Division of Vital Re To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha	letely	Medicai	(Check only one) 2 Medical Exemine	er: On the basis of examination and manner stated.	rledge, death occurred at the ti on and/or investigation, in my o	ne, date and place, and pinion, death occurred	at the time, date ar	s) and manner as stated. nd place, and due to the cause(s)
To th To th	dwoo	ž	29b. Signature and title of certifier	/ ~	29c. Licens	e number	29d. D	ate signed (Month, Day, Year)
		_	/darch Son	1, MY)	Døg	59762	3/-	23/06
			30. Name and address of person who com	/ <b>/</b>	23a) (Type, Print)	WAN	211	01
	Stat	е	Haider Sarra 31. Date filed (Month, Day, Year)	32. Register's Signatu	Eastory & Soule	110	210	0
Re	gistra	ır	MAR 28	2006 Marie	& sperte			

			1 - For State Registrar	State of Maryla		partment of F ertificate of			giene () () 6	11262
	Physici	an	Decedent's Name (First, Middle, L.)	ast)				2. Date of Dea Month	th Day Year	3. Time of Death
	/Medi		James Lowel:	Fowler				MARCH	25 200	6 1555 M
	Examir	ner	4a. Facility Name (If not institution, g.	ve street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	
			Keninsula Region	pal medical G	enter	Sal	Sbury		Wicar	DICO
	Funeral			Sex 7. Age (In yrs	s. last birthda Yrs.	y) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day	Year) 9. Bi	rthplace (State or Foreign ountry)
	Director		147-40-0142 Usual Residence of Decedent	5.6	110.			07/07/1	949 New	Jersey
-/	/land		10a. State 10b. County	10c. 0	City, Town or	Location		<u>.                                    </u>		10d. Inside City Limits
3	Man	ţ	MD Somerse	et P:	rinces	s Anne				1X Yes 2 □ No
40-0143	ours after deeth with the Maryland ret', or items 23a or 28s-f ehow Exeminer must be notified at	Director	10e. Street and Number 12058 Somerset	Avenue		10f. Zip Code 2185	53	1	0g. Citizen of What C	*
0	ns 23	era	11. Marital Status	12. Was Decedent Ever in	118 11			acifu Vac or Na	14. Race - Am	
4	after d or item	Funeral	1 Never Married 2 Married	Armed Forces?		B. Was Decedent of I If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Black, Wh	
# 7 036	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 No If Yes, Give 1967. Year or Dates	-69	1 ☐ Yes 2 No	Specify:		Specify:	White
7 0-0	"naturel",	Completed	15. Decedent's I		16a. Dec	edent's Usual Docur	pation		16b. Kind of Business	/Industry
71	thin 7	npie	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	life	re kind of work done . DO NOT use retire	during most of work d)	ng		
2 2	ed wi	Co	12	none	Re	storer			Furnitur	·e
M	d oth	Be	17. Father's Name (First, Middle, Las	t)			18. Mother's Name	e (First, Middle, I	Maiden Sumame)	
$\exists \beta m_{\ell \leq 1}$	Meni Meni arke	ပ္	Anthony Fowler				Clara Pi	uden		
Fow let, Strict 147 Baltimore, Maryland 21215-0036	permit. Peges 1 end 2 should be filed within 72 ho Depertment of Heelth and Mental Hyglene. Important: If Item 27 is marked other then "naturent injury or other traumatic event, the Medical 2006.		19a. Informant's Name/Relationship		,				, City or Town, State,	
Q 5	end leelth m 27 her ti		Robin S. Fowler						Anne, MD	
Fowler.	Des 1 for H frite or ot		20a. Method of Disposition  Burial 2 ☐ Cremation 3		cemetery, cr	position (Name of ematory or other pla	сө)	Date	20c. Location - City or	Town, State
$z_{\mathcal{L}}$	Per tmen tant:		4 □ Donation 5 □ Other (Spec	(fy) S1					Princess A	nne, MD
39	Depermit Deper Impor eny in		21. Signature of Funeral Service Lice	nsee	1	22 Name and Addre	ss of Facility neral Home			
_	40 F • 0		AHUA LUM	and 1 M0029	9.5	11673 Some	erset Aver	me. Pri	ncess Anne	, MD 21853
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the dea one cause on each line.	ath. Do not e	nter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician	1	mmediate Cause (Final disease or condition	a ESOPHAG	EAL	CARCINO	MA,			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse						
	- Administra	_	Sequentially list conditions,	b. SEPSIS						
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse						
	cate be executed physicien and the burial-transit	хап	that initiated events resulting in death) Last	c. CANDIDET  Due to (or as a conse						
8760,	be ey icien buria			200 (0) 23 2 00130	iquerice or).					
87	cate phys	dic	•	d						
9 ×	The law requires that the death certifics of the best been signed by the ettending prage 2 should be detached for use as t	Physician/Medical	IF FEMALE:	23c. If yes, outcome of pregr	nancy.					
Box	eath e	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fet 4 Pregnant at time of	tal death 3	□Ectopic pregnancy	,		23d. Date of de Month	livery Day Year
o.	the d	ysic	1 ☐ Yes № ☐ No 9 ☐ Unknown	9 Unknown	deau 5	Other (specify)				
P.O.	res that the de igned by the e be detached t		Part II. Other significant conditions	contributing to death but not re	sulting in the	underlying cause giv	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
ds	uires sign d be	d by	1/ =	ALLURE.		, ,		1		robably & Unknown
ò	w requir been si should	Completed								
Re	The lay	m p						24a. Was ar autops perform	y prior to death?	utopsy findings available completion of cause of
a	iclan: The certificate rector, pag		OF Warner of the American	1					Yes 1 ☐ Yes	2 □ No
Division of Vital Records,	Attending Physician: r death. sctor: After this certifice by the funeral director, p	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	750/0	ont 30 DOA Oth	er:			
of	Phy r this ral d	: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time	SIL 3L DOA	4 Li Nuising noi		once 6 Other (Spe	icify)
o	ding th. : Afte	ţ	Natural 5 Pending 2 Accident investigation		Injury	Wor	k? Yes 2 □No			
isi	Attendi	fica	3 Suicide 6 Could not I	De Diese of Isings At I	nome, farm, s			28f. Location (St	reet and Number or R	ural Route Number
Ö	efter Pine din b	Certification:	4  Homicide determined	building, etc. (Spec	ify)	/1 000		City or Town		
	spitu nours noral		29a. Certifier Certifying P	hysician: To the best of my kn	owledge, dea	th occurred at the tin	ne, date and place	and due to the ca	tuse(s) and manner a	s stated.
	To the Hospital or Attent within 24 hours efter death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exa	miner: On the basis of examin and manner stated.	ation and/or	nvestigation, in my o	pinion, death occurr	ed at the time, da	ate and place, and due	to the cause(s)
	To th To th	Me	29b. Signature and title of certifier	1		29c. Licens		29	9d. Date signed (Mont	h, Day, Year)
			> Jenly			000	63199.		3 25 06	
			30. Name and address of person who	completed cause of death (Ite	m 23a) (Type					
			YC	GESH VOHR		EASTERN	J SHORE	DR. SA	LISBURY	MD, 21804
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr's Sign	ature					

			State of Maryland / Department of Health and I  1- State Registrar  Certificate of Death		ZUUb ilZb3
			1. Decedent's Name (First, Middle, Last)	2. Date of Death	3. Time of Death
	Physicia /Medic		BRONNIE LEE FONTAINE	Month 3	Day Year 1228 M
	Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	n	4c. County of Death
			Peninsula legional medical Center Salisbury		Wicomico
	Funeral Director		5. Social Security Number  6. Sex  1 □ M 2 □ XF  7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, )	
			Usual Residence of Decedent	february,11	, 1927 NORIN CARTINAC
	nylan how	_	10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Sa-f e	ecto	MD SOMERSET MARion	·-·-	1 ☐ Yes 2 ☑ No
	filed within 72 hours after deeth with the Maryland Hygien. Viter than "naturel", or iteme 23a or 28a-f ehow ent, ite Mudical Examilier must be notified at	Funeral Director	10e. Street and Number 4778 CRisfield Huy Ex 21838	100	g. Citizen of What Country? U.S. A
	teme	uner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	rs afte	by Fi	1 □ Never Married 2 □ Married 1 □ Yes 2 💆 No 1 □ Yes 2 💆 No Specify: 1 □ Yes 2		Specify: Black
00	2 hou	Completed by	15. Decedent's Education 16a. Decedent's Usual Occupation	. 16	6b. Kind of Business/Industry
215	thin 7	nple	(Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1-4or 5+)  (Give kind of work done during most of work life. DO NOT use retired)	-	arson Seafood Co.
2	led with the the the the the the the the the t		17. Father's Name (First, Middle, Last)  18. Mother's Name		
/lanc	uld be fi Mental H rrked of	To Be	Charlie Carter EHa	ne (First, Middle, Ma H; H	orden Sumame)
-	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Deperment of Health and Mental Hygiene. Important: If time 27 is marked other than "naturel; or iteme 23a or 28a-f show eny injury or other treumatic event, the Mudical Examinar must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Carolyn Schoolfield - Daughter P.O. Box 732 Prince		City or Town, State, Zip Code)
re,	other		20a. Method of Disposition 20b. Place of Disposition (Name of		Oc. Location - City or Town, State
Ë	Pages nent of nt: If It		1 Separate 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  April	1 1,2006	Marion MD
Baltimore,	permit. Depertr Importe eny Inji		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  30639 Hamodea	Funcial	Home MO 21853
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heaft failure. List only one cause on each line.		
	Physician		Immediate Cause (Final disease or condition ACUTE MYDCARDIAL A	NIFA	Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	/ • • / • / • / •	
	Examiner	_	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):		
	nted Insit	Examiner	cause. Enter Underlying Cause (Disease or injury		
o,	exect an and rial-tra		that initiated events c. Due to (or as a consequence of):		
8760,	The law requires that the death certificate be executed the bas been signed by the attending physicien and page 2 should be detached for use as the burial-transit	dicai			
39 )	artifica ling ph e as th	Med	IF FEMALE:		
Вох	leath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of delivery  Month Day Year
P.O.	that the de led by the a detached i	yslo	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		
υ, Ο	res that igned b be deta	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
rds	w require: been sig should b	ed b	EIRI) - AD	1 ☐ Yes	2 No 3 Probably 4 Unknown
Records,	hes be	plet	CHF.	24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
<u> </u>	yelclan: The is certificate ho director, page	Completed		performe 1 ☐ Yes 2)2	d'y death?
Vital	ilclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	th (Check only one)	
0	Phys r this ral dir	2		ome 5 Resident	ce 6 Other (Specify)
O	ttending F death. :tor: After r the funer	tlon	27. Manner of Death  VENatural 5 □ Pending (Month, Day Year)  28a. Date of Injury 28b. Time of Injury Work?  (Month, Day Year)  Accident investigation  28b. Time of Injury Work?  1 □ Yes 2 □ No	200. 000011201100	injury occurred
Division of	r Atteller des	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	pital o				
	Hos 24 ho Fun etely t	Medical	29a. Certifier (Clieck only)  2   Madical Examiner: To the best of my knowledge, death occurred at the time, date and place (Clieck only)  2   Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation, in my opinion, death occurred at the time, date and place of examination and/or investigation and occurred at the time, date and place of examination and occurred at the time, date of examination and occurred at the time, date of examination and occurred at the time, date of examination and occurred at the time, date of examination and occurred at the time, date of examination and occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the time, date occurred at the	, and due to the cau rred at the time, date	se(s) and manner as stated.  and place, and due to the cause(s)
	To the Hospital or Attending Physician: within 24 hours state death To the Funeral Director: After this certifice completely filled in by the funeral director; p	Me	296 Signature and title of certifier 29c. License number	290	Date signed (Month, Day, Year)
			Me Male Nacholder D-53	611 3	3/22/06
			30. Name and more ss of person who close letted cause of death (Hem 23a) (Tyre Print)	611 = usbug	/
				usour	MD
	Sta Registra		731. Date filed (Month, Day, Year)  MAR 2 8 2006		

			For - State Registrar	State of M	arylan	nd / Depa <i>Cei</i>	artme <i>rtifica</i>	nt of H	ealth D <i>eath</i>	and Me		giene Reg. No.	006	11264	
4000	Physici /Medic		Decedent's Name (First, Middle, La     CARL	GIAM	PAPA						2. Date of De Month	aath Day	2006	3. Time of Death 3:00 A M	
#1	Examir		4a. Facility Name (If not institution, give Manorcare Potom	ac			Pc	y, Town, or tomac		of Death		4c. Mo	County of De	ry	
*	Funeral Director		5. Social Security Number 6. S  084-10-1969	M 2 F	90	last birthday) Yrs.	Month		Hours	Min.	8. Date of Bir (Month, Da ept.16	iy, Year)		irthplace (State or Foreign Country) nsylvania	
	the Maryland 28a-f show cutified at	ector	10a. State 10b. County VA Fairfax  10e. Street and Number			ty, Town or Lo IcLean		ip Code				10- 69		10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	23a or	Funeral Director	6800 Fleetwood R	oad #401			101. 2	22101				_	zen of What (	country ?	
3036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "naturel", or Items 23e or 28e-f show shy injury or other traumatic event, the Medical Exaciling frault by notified at once.	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Armed Forces: 1,	, No WWI	I	f Yes, sp	edent of Hi ecify Cuba 2 No	spanic Or n, Mexica Specify	n, Puerto R	ify Yes or No ican, etc.)		14. Race - Am Black, Wh Specify: W		
Maryland 21215-0036	within 72 h ene. than "natu	Completed	15. Decedent's En (Specify only highest grade) Elementary/Secondary (0-12) 1 2	ducation de completed) College (1-4or	5+)		kind of v DO NOT	ual Occupa rork done d use retired, /Owne	luring mos )	st of workin	g		nd of Busines		
nd 2	be filed tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Last,			Hall	agei	/ Owne	18. Moth		(First, Middle		staura Sumame)	II C	
aryla	should nd Men marke imaric	2	Damiano Giampapa  19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Addre	ss (Street a		a Pie		er, City or	Town, State,	, Zip Code)	
	and 2 lealth a m 27 is		Nancye Mittendor	ff - daugl		6800	F1ee	twood	Rd.	#401	McLe	an,V	A 2210	1	
Baltimore,	Pages 1 lent of h nt: If ite ry or ot		20a. Method of Disposition  **Disposition   Cremation   3   4   Donation   Other (Specification   Control			Place of Dispo cemetery, crem nt Com				Da 03/25			,		
Balti	permit. Departmit. Imports any inju		21. Signature of Juneral Service Licer	See Sum	, (	_1			+		1			•	
· ·	Physician /Medical		23a. Part . Enter the disease, or own shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that cause one cause on each l						cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death	
8760,	Examination and bursician and stife bursi-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a conseq	uence of):									
Division of Vital Records, P.O. Box 687	Attending Physicism: The law requires that the death certificate it death.  sclor: Atter this certificate has been signed by the attending physicator: Atter this certificate as been signed by the funeral director, page 2 should be detached for use as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Ves 2   No 9   Unknown   Unknown   Unknown   Part II Other significant conditions contribution to death but not negligible.				Ideath 3	Ectopic Other	pregnancy specify)				2	3d. Date of d	elivery Day Year	
rds, P	w requires that been signed b should be deta	Ď	Part II. Other significant conditions of DEMENTO		out not res	ulting in the u	nderlying	cause give	n in Part	l.		pheatley Funeral Home andria, VA 22302  The property of the cause of death?    23d. Date of delivery Month Day Year			
al Reco	r: The law requicate has been ; page 2 should	Completed	Copp.								perfo	osy ormed?	death?		
Ž	ysiciar is certif directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2⊠No	Hospital:	ent 2 🗆	ER/Outpatien	it 3 🗆 🛭	Othe	r		Check only o		☐Other (Sp	ecify)	
o uoi	ath. ath. or: After th	ation: 1	27. Manner of Death  1 SNatural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da	ry y Year)	28b. Time of Injury	М	28c. Injury Work 1 🗆 Y		28	d. Describe			,	
Divis	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	ome, farm, str	eet, facto	ry, office		28	of Location ( City or Tox	Street and wn, State)	d Number or F	Rural Route Number,			
	To the Hospital or within 24 hours afte fo the Funeral Dir completely filled in	Medical	29a. Certifier (Check only one)  Volume Certifying Ph 2 Medical Exam	wledge, death tion and/or inv	occurre estigation	d at the tim in, in my op	e, date ar inion, dea	nd place, ar ath occurred	nd due to the d at the time,	cause(s) date and	and manner a place, and du	as stated. ue to the cause(s)			
	To the Howithin 24 To the Fu	Me	29b. Signature and title of certifier					O O		566			signed (Mor	nth, Day, Year)	
9'	(4)		30. Name and address of person who					Q	0 (1	2,2.	10/0	Call	M D 2	12.81	
	- Sta Registr	_	Suncha Bhogo 31. Date filed (Month, Day, Year) MAD 2.8 2006	2. Registr	ar's Signa	sture force	1	VICE	, , , (20)	11270	1	50,0	1.,116	, - 16	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#18,perinf, 0854,4/24/06 TIL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No." 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 1 **Physician** 03 21-2006 John George Grove, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Annapolis Anne Arundel Medical Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 18, 1926 5. Social Security Number Washington, D.C. **Funeral** 1 X M 2 ☐ F 80 578-22-7156 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury of other traumatic event. If a Madical Exacilinar mast be notified at once. 1 X Yes 2 No Cape Coral Florida Lee Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1516 N.W. 38th Place 33993 United States Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 11 Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlotte Mary John George Grove, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 321 William Way Stevensville, Maryland 21666 Lynn M. Grove -daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 National 2 □ Cremation 3 □ Removal from State

4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery 3/29/2006 Brentwood, Maryland 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 1. 13 cm Honald V 4400 Powder Mill Road Beltsville, Maryland 20705 w 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Dreumonia Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The taw requires that the death certificate be executed burial-tran and Due to (or as a consequence of) .O. Box 68760, Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery use 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav for in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy rector, page 2 s 2 🔀 No 2 X No 1 Yes 1 Yes Division of Vital or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Appatient 2 ER/Outpatient 3 DOA ို 1 ☐ Yes 2 ZNO this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Magner of Death 28a. Date of Injury (Month, Day Year) Certification: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funerel Director: / completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of conficer 3-24-2006 D24804 - MID +1 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annopoles Md 21401 eterson MD 32 Registrar's Signature

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 28

2006

			For State Registrar	State of M	aryland	•	rtment of F		d Mental H	ygiene	6 11266
	Physici	3 D	Decedent's Name (First, Middle	a, Last)					2. Date of E Month		Year 3. Time of Death
	/Medic	al	Donald Carlt		1		4). O't. T.		marc	1 26 20	006 20:12 M
- 3	Examir	ier	4a. Facility Name (If not institution  Washington C		_		4b. City, Town, o	erstown		4c. County	ngton County
Ž.	Funeral	÷	5. Social Security Number	6. Sex 7. A	ge (In yrs. las		If Under 1 Year Months Days	If Under 24		lirth (Pay, Year) 2 1923	Birthplace (State or Foreign Country)
A CONTRACTOR	Director		235–28–3102 Usuel Residence of Decedent	1 <b>X</b> ]M 2□F	82	Yrs.		110010	Sept	2 1923	West Virginia
	yland now		10a. State 10b. County		10c. City, 7	Town or Loc	cation				10d. Inside City Limits
	e Mar	ctor	Maryland Wash	ington		Нас	gerstown				X□Yes 2□No
	with th	Funeral Director	10e. Street and Number	midaa Duirra			10f. Zip Code	740		10g. Citizen of V	·
	ns 234	erai	711 Knightsb	12. Was Decedent	Ever in U.S.	13. V		740 Hispanic Origin	? (Specify Yes or N		J.S.A.
9	or Item	Fun	1 ☐ Never Married 2 ☐ Marr	Armed Forces	7	/43	Yes, specify Cub  ☐ Yes ※☐ No		? (Specify Yes or Nuerto Rican, etc.)		ck, White, etc.
5-0036	urai',	d by	3  Widowed 4 □ Divorced	Year or Dates:		/45		Specify:		Specify	WILLCC
-212	n "nat	Completed	15. Deceden (Specify only highes	t grade completed)		(Give I	ent's Usual Occup kind of work done OO NOT use retire	during most of	working	16b. Kind of Bu	usiness/Industry
212	giene.	mo.	Elementary/Secondary (0-12)	College (1-4or	5+)	I	Aircraft	Superv	isor	Aircra	ift Mfg.
nd	ould be filed within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Items 23a or 28a-f ehow attic event, the Medical Examinar must be notified at	Be	17. Father's Name (First, Middle,	Last)				18. Mother's	Name (First, Midd	le, Maiden Suman	10)
Maryland	s 1 and 2 should be f Health and Menta Item 27 ie marked other traumatic ev	은	Stanley L. Gru	hhs Sr		19h Mailin	a Address (Street		llie A. C		State Zin Code)
	od 2 :		Donna C. Stick	, , , , , ,					gansville		
Z.	of Head of Head fitem r othe		20a. Method of Disposition		20b. Plac	e of Dispos	sition (Name of latory or other pla	-	Date		City or Town, State
altimore,	Pages ment of ant: if the ury or o		1 Surial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		1	Haver	n Cemeter	cy 3	-30-06		own Maryland
gai	permit. Pages Department of Important: if if eny injury or o		21. Signature of Funeral Service	Licensee							Fuenral Home
		1	23a. Part 1. Enter the disease, or	complications that cause	d the death.	Do not ente	331 Easte or the mode of dyi	ern Blve	d. N. Hac	erstown .	Maryland 21742 Approximate
	Physician		shock, or hear failure. List Immediate Cause (Final disease or condition	only one cause on each I	ine.	141/1	WARRI	à1 /	NELLOC	TIDA	Interval Between
	/Medical		resulting in death)	a. Due to (or as	a consequer	nce of):	CAKWII	96 (1	MATE	110/4	15 VOLS
	Examiner	_	Sequentially list conditions,	b. AK7/5	RIOSC	4-120	TIC CO	MONA	RY ARTIS	RY DISE	NE 15 YEARS
	uted 1 Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequer	ice or).					
o	be executed sician and burial-transit		that initiated events resulting in death) Last	c. Due to (or as	a consequer	nce of):					
09/8	ate be	licai		d			·				
Ď X	law requires that the death certificate as been signed by the attending phys 2 should be detached for use as the	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregnance	v				004 0-4	A
ROX	death dath d	Ician	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant a	2 Fetal de	eath 3 🗆	Ectopic pregnancy Other (specify)	/		23d. Dat Mo	te of delivery onth Day Year
J.	by the	hys	9 Unknown	9□ Unknown							
_	res that the de signed by the a be detached f	by	Part II. Other significant condition	ns contributing to death t	out not resultin	ng in the un	derlying cause giv	en in Part I.			mbute to the cause of death?
cords	w requir been si should I	eted							_		3 Probably 4 Unknown
d)	0 4 0	Completed								opsy /	Were autopsy findings available prior to completion of cause of death?
VItal	ician: Th certificate rector, pag	0	25. Was case referred to fiedical			1		26 Place of	1 ☐ Yes Death (Check only	- V	1 ☐ Yes 2 ☐ No
010	y 8	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpati		VOutpatient	3□ DOA Ott	er: 4 🗆 Nursir	ng Home 5 □ Re		er (Specify)
	ding Ph h. After th tuneral		27. Manor of Death 1 Natural 5 ☐ Pendin		ny Year) 28	Bb. Time of Injury	28c. Injur Wor		28d. Describe	how injury occurr	red Der
UIVISION	C # :: 0	ficat	2 Accident investig 3 Suicide 6 Could r		iury - At home	e, farm, stre		Yes 2□No	28f. Location	(Street and Numb	per or Rural Route Number,
2	el or / s after of Dire	Certification:	4  Homicide determ	building, e	ic. (Specify)		et, factory, office			own, State)	
	To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by th	cal	29a. Certifier 1 → Certifyin (Check only 2 ☐ Medical	g Physician: To the best Examiner: On the basis of	of my knowle	edge daeth and/or invi	conumed at the tir	ma data and p	lane, and due to the	e date and place	and due to the cause(s)
	To the P within 24 To the F complete	Medical	one)  29b. Signature and title of certifier	and manner st	ated.		29c. Licens		Joedhad at the time		d (Month, Day, Year)
	1.1		Pal Hall	MM Pentrual	Plarte	Jan	250. 210	01/2	7-03		
1	24	1	30. Name and address of person	who completed cause of	deam (Item 23	3a) (Type, F	Print)	045	5 /		27, 2006
	42	į.	NOBERT BRULL	(D) 1459 f	DIDMA	IC Si	T. ( (AC	ERSTO	DWW, 17	1 2/7	42
Contract of the Contract of th	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ar's Signatur	e .	mag a	•	(		
Paris		4	411/11/	THUVU SAMERICA	and a street a	1550	Regulation of				

			For State Registrar	State of I	Marylan		artment rtificate			and M		giene	5	11267
di di	Physici	an	Decedent's Name (First, Middle DANIEL	e, Last) JEROME	GLU	CK					2. Date of Dea	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution			CK	4b. City, To	own or	Location o	of Death		25 200 4c. County		11:50 A M
	Examin	ier		K MEMORIAL		TAL	FRED					FREDE		
200	Funeral Director		5. Social Security Number 073-40-6422	6. Sex 7. 1 ☑ M 2 □ F	Age (In yrs.	last birthday) Yrs.	If Under 1 Months	Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day DEC . 25	, Year) 5,1948	Cou	place (State or Foreign intry) York
	and W		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Mary!	rot	·	lerick		Frede								1 ☐ Yes 2 ☒ No
	r 28a	Director	10e. Street and Number		1		10f. Zip C	ode				10g. Citizen of	What Cou	intry?
	23a c	alD	1315 Mulberr	y Court				2170	)3			United	St	ates
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or iteme 23a or 28a-f ehow is marked other than "natural", or iteme 23a or 28a-f ehow reumatic event, the Macalcal Extendent calls be mailtied at	by Funeral	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced	If Vas Give	is? □ No		Was Deceder f Yes, specify	y Cubar	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	ecify Yes or No- Rican, etc.)		ck, White	ican Indian, , etc. ite
5	72 ho 'natur	eted	15. Deceden (Specify only highe	it's Education st grade completed)		(Give	dent's Usual (	done di	uring most	of worki	ng	16b. Kind of B	usiness/lr	ndustry
21	within ne. then	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life.	DO NOT use y Pol:	retired)		icer		Norr V	orle (	C:+
2	filed v Hygie other i	o Co	17. Father's Name (First, Middle,	Last)		CIL	.y FOI.	rce			(First, Middle,	New Y		CILY
ylan	ould be I Mental Parked o	To Be	Edward		uck						y Jean			
<u>g</u> a	d 2 sh th and th sh traun		19a. Informant's Name/Relations mary Ellen Glue									r, City or Town, ck, Mar		
Baltimore, Maryland 21215-0036	Pages 1 and 2 should bent of Health and Mentinit: If Item 27 is marked ity or other traumatice		20a. Method of Disposition  1  Burial 2  Cremation 4  Donation 5  Other (S	3 □Removal from Sta	ite C	Place of Dispo cemetery, crer	sition (Name natory or othe	of er place	9)	D	ate	20c. Location	City or T	
Ħ	그 문문을 .		21. Signature of Funeral Service		/									es, P.A.
ñ	perm Depa impo any i		Brukmon	Bete	Ren							ederick		
Ī	Physician		23a. Part 1. Eors the disease, or shock, or heart failure. List Immediate cause (Final disease or condition	r complications that cause only one cause on each	sed the death	h. Do not ent	er the mode	of dying	, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
18 20	/Medical Examiner		resulting in death)		as a conseq	uence of):	VD							
4	cuted of the sansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or	as a conseq	uence of):								
8760,	cate be executed physician and the burial-transit	dicai Ex	resulting in death) Last	Due to (or	as a conseq	uence of):								
39 ×	ertifica ding ph	/Med	IF FEMALE:	23c. If yes, outcor	To al orange									
O. Box	The law requires that the death certific lie has been signed by the ettending p age 2 should be detached for use as i	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 4 Pregnant	2 ☐ Feta t at time of d	Ideath 3	Ectopic preg Other (spec						te of deliventh	rery Day Year
rds, P.	w requires that the de been signed by the e should be detached f	by	Part II. Other significant condition	ons contributing to death	but not res	ulting in the u	nderlying cau	se give	n in Part I.		23e. Did to	,		the cause of death? bably 4 □Unknown
ဝင္ပ	law reas bee	Completed		net la	ryper	ed (	2a				24a. Was a	an 24b.	Were aut	opsy findings available ompletion of cause of
		Com									perfor	med?	death? 1 ☐ Yes	
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medica examiner?	Hospital:				Othe	-		(Check only or			
ō	Phys r this ral dir	1: To	1 Yes 2 No 27. Manner of Death	28a. Date of I		ER/Outpatien		1	4 🗆 140			ence 6 Oth		(fy)
on	nding Ph ath. r: After th e funeral	atior	1 Matural 5 ☐ Pendir 2 ☐ Accident investi	'9	Day Year)	Injury	м	: Injury Work 1 🗆 Y	? ′es 2□!	No				
Division of Vital Records,	al or Attendi s after death. Il Director: A id in by the fu	Certification:	3 Suicide 6 Could determ	nined   288. Place of	Injury - At he etc. (Specif	ome, farm, str	eet, factory, o	office		1	28f. Location (S City or Tow	Street and Numb n, State)	er or Rur	al Route Number,
	To the Hospital or Attending Physician: within 24 hours after dear Minit 24 hours after dear Minit 25 hours for the Funeral Director. Yeter the removed property filled in by the funeral director, completely filled in by the funeral director,	edicai	29a. Certifier 1 Certifyir (Check only one) 1 Medical	ng Physician: To the be Examiner: On the basis and manner	s of examina	wledge, death	n occurred at vestigation, in	the time	e, date and inion, deat	d place, a	and due to the ded at the time, d	cause(s) and madate and place,	anner as a	stated. to the cause(s)
	To the To the complet	M	29b. Signature and title of certifie	Ol	1		29c. l	icense [] [	number (	49		29d. Date signe	d (Month,	. Day, Year)
الم	1/h		30. Name and address of person	completed cause of	death (Item	n 23a) (Type,	Print)					-		.701
0			U. Davidlad (14 at 2	1-4n H	MKI	124 ]	M	,	400 W	Vest	Seventh	n St./ 1	rede	erick,MD
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2	8 2006 32.	strar's Signa	B A	porte							

			1 For State	State of Man				Mental Hyg	iene	11000
			Registrar		Ce	rtificate of	Death		eg.No.UUb	1200
4	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year	3. Time of Death
4.	/Medic		Maxine Hollis  4a. Facility Name (If not institution, give s			4b City Tourn	or Location of Dea	March	4c. County of Dear	
141	Examin	er	Southern Maryla		tal	Clint		(41	Prince (	
*	Funeral		5. Social Security Number 6. Sex		n yrs. last birthday	If Under 1 Year	If Under 24 Hrs			thplace (State or Foreign
Jaka	Director		187-32-1009 <sup>1</sup>	M 2□ <b>x</b> F	62 Yrs.	Months Days	Hours Min	(Month, Day Aug. 22	1943	PA
	pu ,		Usual Residence of Decedent	140	Oc. City, Town or L					1
	anyla ehov	5	10a. State 10b. County							10d. Inside City Limits 15€ Yes 2 ☐ No
	28a-f	ecto	Md. PG		Distric	t Heigh	its		log. Citizen of What Co	••
	with with	by Funeral Director	2503 Romona Dri	i vo		2074	17		United S	·
	me 23	era		2. Was Decedent Eve	or in U.S. 13.	Was Decedent of If Yes, specify Cub		Specify Yes or No-	14. Race - Ame	
9	or Ite	F	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☑ Yes 2 ☐ No				to Rican, etc.)	Black, Whit	e, etc.
93	ours.	dby	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify: B1	ack
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Iteme 23a or 28e-f ehow ther the Mazilcal Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		(Giv	edent's Usual Occu e kind of work done	during most of wa	rking	16b. Kind of Business	/Industry
12	withir ene. than	ш	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retire	*	er	DC Corre	ections
Q 2	should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other than "naturel", or Iteme 23a or 28a-f ehow marked other than "naturel", or Iteme 23a or 28a-f ehow marke event, the Madical Examinar must be notified at	CO	17. Father's Name (First, Middle, Last)		COLL	CCCIONA		me (First, Middle,		
an	Mental Mental arked o	To Be	Frank Hollis				Lillie	Burge	SS	
Maryland	shou and M s mar		19a. Informant's Name/Relationship (Typ	pe, Print)	19b. Mai	ing Address (Stree	and Number or R	ural Route Number	, City or Town, State, 2	Zip Code)
Σ	and 2 saith a n 27 i		Joe Gaston/husb	and	Dis	3 Romon trict H	a Drive eights,	Md. 20	747	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic ex ance.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re	1	20b. Place of Disp	osition (Name of ematory or other pla	!		20c. Location - City or	Town, State
Ë	Pag ment tant: jury c		4 ☐ Donation 5 ☐ Other (Specify)			coln Ce			Brentwoo	
Sali	Departition of the control of the co		21. Sign flure of Funeral Service License	e de	4	2. Name and Addr			& Edwards	
	40240		222 Port Enter the disease or compli	Mutu					Suitland,	
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.	- Geath, Do not er	iter the mode of dy	ng, such as cardia	c or respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Oue to fee as a se		2000				
	Examiner			Due to (or as a co	onsequence or):					hours
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a co	onsequence of):					
Þ	nd	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c.							
8760,	sate be executed physicien and the burial-transit		resulting in death) Last	Due to (or as a co	onsequence of):					
876	Attending Physician: The law requires that the death certificate be executed to death.  act of alth.  actor: After this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit.	dicai	d.							
Box 6	eath certific attending p	Physician/Med	IF FEMALE:	3c. If yes, outcome of p	pregnancy				224 0040 04 40	- Aviic - a - ar
BG	death atter	clar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth 2☐ 4☐Pregnant at tim	Fetal death 3:	☐Ectopic pregnand ☐ Other (specify) _	·y		23d. Date of del Month	Day Year
о. О	t the c by the achec	hysi	9 Unknown	9□ Unknown		., ,,				
ώ.	res that the de signed by the a i be detached i	P V	Part II. Other significant conditions cont	tributing to death but n	ot resulting in the	underlying cause gr	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ğ	w require been sig should b		Coronan	d oute	عمر د	1.5265	د	1 🗆 Yı	es 200 No 3□Pr	obably 4 Unknown
Records,	e law r has be je 2 sh	Completed	Congas	tive b	fred	Feirly	~	24a. Was a autops		utopsy findings available completion of cause of
<u>=</u>	The I	Con	ن					perfor	ned2 death?	2 🗆 No
Division of Vital	rding Phyeician: Th th. : After this certificate funeral director, pag	Be	25. Was case referred to medical examiner?	anital.	,	100		ath Check only on	18	
of	Physic this c	10	1 Yes 2 No	28a. Date of Injury	2 X ER/Outpatie	III JUDON			ence 6 Other (Spe	city)
no	ding h. After funer	tion	1 Natural 5 Pending	(Month, Day Ye	ear) Injury	Wo	rk? ]Yes 2∐No	280. Describe no	ow injury occurred	
/isi	Attender death	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home, farm, s			28f. Location (Si	reet and Number or Ru	ural Route Number,
ó		Certification:	4  Homicide	building, etc. (5	Specify)			City or Town	n, State)	
	To the Hospitel or Attenwithin 24 hours after deation to the Funeral Director: completely filled in by the		29a. Certifier (Check only 2 Medical Examin	ician: To the best of m	ny knowledge, dea	th occurred at the tr	me, date and place	and due to the c	ause(s) and manner as ate and place, and due	stated.
	To the H within 24 To the Fi complete	Medicai	Ulle)	and manner stated	i.					
	To To con	Ž	29b. Signature and title of certifier				se number		9d. Date signed (Monti	* * * * * * * * * * * * * * * * * * * *
7			1 3/10	1	$\langle \cdot \rangle$		6300	10	3/28	15000
	3		30. Name and address of person who cor	npleted cause of death		. ,		בי בת		0077
45	Sta	te	31. Date filed (Month, Day, Year)	Registrar's		7503 80	irratts	ка., C1	inton,Md.	20735
	Registr		APR 1 0 2006	Marie	El 438	and the same of th				

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April 1,2006 3:00 P. M Charles Allen Grace, Sr. 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Harford Havre de Grace 703 Tydings Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 10/15/1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1⊠M 2□F 80 Yrs Maryland 220-14-8771 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No Harford Havre de Grace MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21078 U.S.A. 703 Tydings Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XYes 2 No WWII If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Civil Service 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Eva Walters James Preston Grace 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21078 Mrs. Cassie P. Grace (Wife) Havre de Grace, Maryland 703 Tydings Rd. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4/4/06 Aberdeen, Maryland Harford Mem. Gdns. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final month disease or condition resulting in death) Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Year Month 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medicat examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 ▼No 2 ☐ ER/Outpatient 3 ☐ DOA 5 KResidence 6 □Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending investigation

Physician /Medical Examiner the attending physician and hed for use as the burial-transit The taw requires that the death certificate be executed

Examiner

Physician/Medical

þ

Completed

Be

P

Certification:

Medical

3 ☐ Suicide

29a. Certifie

4 Homicide

**Physician** 

**Examiner** 

Director

Funeral

à

ed

Complet

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show amy injury or other traumatic event, the Medical Evantment must be rediffed at ance.

Baltimore, Maryland 21215-0036

/Medical

been signed by the should be detached funeral completely filled in by the

has

certificate Physician:

Director: After or Attending

death.

after

24 hours

To the within 2

Division of Vital Records, P.O. Box 68760,

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

6 Could not be determined

29c. License number D45530 29d. Date signed (Month, Day, Year)

asaelam MID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4-4-06 5 Atwood road Belai 21014

State Registrar 31. Date filed (Month, Day, Year) APR 1 0 2006



		•	1 - For State Registrar	State of Marylan			nt of H		nd M		giene Reg. No.	006	11270
	Physici	an	Decedent's Name (First, Middle, Last     MOZELLE F. GO.							2. Date of De Month March		006 Year	3. Time of Death 8:30 A M
	/Medic Examin		4a. Facility Name (If not institution, give 11701 Whittier Rd			4b. City		Location of			4c. (	nce Ge	th
	Funeral Director		370-40-3400	7. Age (In yrs.	ast birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 24 Hours	Min	8. Date of Bir (Month, Da Oct 1,	iv. Year)	Co	thplace (State or Foreign buntry) hington DC
	a-f show	ctor	Usual Residence of Decedent           10a. State         10b. County           MD         Prince G		y, Town or Lo	cation							10d. Inside City Limits 1    Yes 2 □ No
	sa or 28	i Dire	10e. Street and Number 11701 Whittier Ro	1			0721				_	en of What Co	-
036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heatin and Mental Hydiene. Department of Heatin and Mental Hydiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show amy properant: if Item 27 is marked other than "natural", or items 23a or 28a-f show amy fujury or other traumatic event, the Madical Examinar most be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	1	Was Dece if Yes, spi 1  Yes	cify Cubai	spanic Origi n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No Rican, etc.)		4. Race - Ame Black, Whit Specify: B1a	e, etc.
Maryland 21215-0036	i within 72 hor iene. r then "naturi	Completed	15. Decedent's Edd (Specify only highest grad		16a. Deced (Give life. I	kind of w DO NOT	ork done d ise retired,	ntion furing most ( )	of workir	ng		of Business	/Industry
land 2	uld be filed Mental Hyg irked other itic event,	To Be C	17. Father's Name (First, Middle, Last)  James Merkerson							(First, Middle Philli		Sumame)	
, Mary	end 2 sho satth and h n 27 is ma		19a. Informant's Name/Relationship (7) William A Gorham /	Son	308 F	ernd	ale F		n Hi	.11 MD	20745		
Baltimore,	Pages 1 ment of He tant: If Iter jury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State G16	lace of Dispo emetery, crer enwood	Ceme	etery	3-	-25-		Wash	ation - City or ington	
Ball	Departit Depart Import any in		of Funeral Service Licens	E Wa		on DC	ome 20020						
	Physician /Medical Examiner	ner	if any, leading to immediate	a. Corona  Due to (or as a consequence)	vy to pertendence of):	lear	t t	) i sea		respiratory a	rrest,		Approximate Interval Between Onset and Death
8760,	cate be executed physicien and the burial-transit	dicai Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conset	poethi ence of):	Noi	disi	n					
.O. Box 6	death certifi e ettending od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	33c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic (	pregnancy				2	3d. Date of de Month	livery Day Year
Δ.	w requires that been signed b should be deta	by	Part II. Other significant conditions co	ntributing to death but not res	utting in the u	nderlying	cause give	en in Part I.			obacco us Yes 2		o the cause of death? robably 4%[Unknown
Division of Vital Records,	The fa ete hes page 2	Completed								24a. Was auto perfo 1 🗆 Yes		24b. Were au prior to death?	utopsy findings available completion of cause of
fVit	Physicien: Th this certificete ral director, pag	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 3 ☐ No	Hospital: 1   Inpatient 2	ER/Outpatier	nt 3 🗆 D	OA Othe			<i>(Check only</i> only one 5 🙀 Resi		☐Other (Spe	ocify)
ion o	After fune	ertification;	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	М	28c. Injury Work	at ⟨? Yes 2 □ N		8d. Describe	how injury	occurred	
Divis	우류물드	O	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specif	/) 					City or To	wn, State)		ural Route Number,
	e Hospitel 24 hours a Funeral letely filled	edical	29a. Certifier 1 X Certifying Phy one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, death tion and/or in	h occurre vestigatio	d at the tim	e, date and pinion, death	l place, a h occurre	nd due to the ed at the time;	date and	and manner as place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	) (		25	c. License					signed (Mont	-2
	2		30. Name and address of person who a DCC-ACC, 1900-1	enweed.  proported cause of death (Item  Accorp. his eath	23a) (Type,	Print)			ina	ton		2000	
	Sta Registi		31. Date filed (Month, Day, Year)  MAR 2 7 2006	2. Registrar's Signa				- 211			<b>*</b> , ,	W-00	

		1 - For State Registrar	State of Ma	arylan		artmen rtificat				giene Rag. No.	06	1271
() Dhysia	ion	1. Decedent's Name (First, Middle	e, Last)						2. Date of De	aath Day	Year	3. Time of Death
Physic /Medi		Theodore Jose							March	25,	2006	7:15p <sup>M</sup>
Exami	ner	4a. Fecility Name (If not institution				4b. City,		Location of Death	n		County of Deal	
		Larkin Chase Nu			last birthday)	If Under	Bot	Vie If Under 24 Hrs.	8. Date of Bi			eorge S
Funeral Director		216–12–9239	1 <u>M</u> M 2□F	86		Months	Days	Hours Min.	10/14/	ay, Year)	9. Dill	ountry) MD
		Usual Residence of Decedent				1			10/1/4/	1919		PID
how		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. Inside City Limits
ith the Marylar or 28a-f show	ctol	MD C	alvert			Н	unti	ngtown				1 to Yes 2 □ No
ith th	Director	10e. Street and Number				10f. Zip	Code			10g. Citiz	zen of What Co	ountry?
ath w	E		rive	r*				20639			USA	
iten de	Funeral	11. Marital Status 1 □ Never Married 2 🐼 Marr	12. Was Decedent Armed Forces? ied 1 ∰Yes 2 ☐!		.5. 13.	Was Deced	ent of Hi offy Cuba	ispanic Origin? (S n, Mexican, Puert	o Rican, etc.)	)	<ol> <li>Race - Ame Black, Whit</li> </ol>	
iled within 72 hours after death with the Maryland Hygiene. Hygiene. Wher than "natural", or itema 23a or 28a-f show into the Medical Examination indiffed at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	ww :		1 🗆 Yes	2 <b>∭</b> No	Specify:			Specify: W	Mite
2 hou		15. Deceden		VVVV	16a. Dece	dent's Usua	al Occupa	ation		16b. Kir	nd of Business	Industry
hin 7.	Completed	(Specify only highest Elementary/Secondary (0-12)	college (1-4or 5	5+)	life.	kind of wo DO NDT u	rk done d se retired	during most of wor ()	rking			
or th	Con	12			Vendir	ng Mad	hine	e Repair			ding Ma	chines
be file d oth	Be	17. Father's Name (First, Middle,	Last)					18. Mother's Nan	ne (First, Middle	, Maiden :	Sumame)	
and yield of the state of the s	2	unkn					į		unkno			
ie, intally idation with the Maryla stand 2 should be filed within 72 hours after death with the Maryla Health and Mental hygiene. If the 12 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Medical Examination in a rectified at		19a. Informant's Name/Relations	, , , , , ,		1			and Number or Ru		- '		
ges 1 and 2 t of Health If item 27 or other tra		Faye Meyer/Dau	hter	20h F	1409 Place of Dispo			on Place	Crofto		D 21114 cation - City or	
		1   Burial 2 □ Cremation			emetery, crer	natory or o	ther plac	' (				
it. Partimer		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		So	. Memor				9/2006			Maryland
permit. Page Department of Important: If any injury or one.		▶ C, Wa	77				100	B. Dunki	aymond-W			).A.
Mark Street		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each li	I the deat								Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Cau	V100	( 7	1	lon					Onset and Death
/Medical		resulting in death)	Due to (or as	a conseq	uence of):	rt	A	1101				
Examiner	_	Sequentially list conditions, if any, leading to immediate	b. tal	lu	e	01	Wi	le				
pe is	lue	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseq	uence of):							
xecut and af-trar	Examiner	that initiated events resulting in death) Last	c Due to (or as	a conseq	uence of):							
licate be executed physicien and sthe burial-transit	alE											
	edical		u									
leath certifi attending	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □Live birth			Tratage of	22			2	3d. Date of del	ivery
deat deat	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at			Ectopic pr Other (sp					Month	Day Year
by the	hys	9 Unknown										
The law requires that the death certisted has been signed by the attending sage 2 should be detached for use a	by	Part II. Other significant condition	ons contributing to death b	ut not res	ulting in the u	nderlying c	ause give	en in Part I.				the cause of death?
require been si should I	Completed	Jeune								Yes 2□	]No 3□Pr	obably 4 Unknown
ne law has b	현				<del></del>				24a. Was auto	psy	prior to	topsy findings available completion of cause of
: The	S								1 Tes	2/ No	death? 1 ☐ Yes	2□ No
tending Physician: The isath.  for: After this certificate his the funeral director, page	Be	25. Was case referred to medical examiner?	Hospital:				Othe	26. Place of Dea				
Phys rahis	. To	1 ☐ Yes 25 No 27. Manner of De th	1 ☐ Inpatie		ER/Outpatier 28b. Time of		A	4 A Nursing H	lome 5 Resi			cify)
After	tlon	1 Natural 5 Pendin 2 Accident investig	g (Month, Da	Year)	Injury	м	8c. Injury Work	(? Yes 2 □ No	200. 2000100	now injury	00001100	
Atten deat ctor: y the	flca	3 ☐ Suicide 6 ☐ Could i	not be 28e. Place of Inj	ury - At he	ome, farm, str				28f. Location (	Street and	d Number or Ri	ural Route Number,
rs after al Dire	Certification:	4 Homicide	building, et	c. (Specif	ý) 				City or To	wn, State)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely illed in by the funeral director,	edical	29a. Certifier (Check only one) Certifyin 2 Medical	g Physician: To the best Examiner. On the basis of and manner sta	examina	wledge, death	occurred vestigation	at the tim , in my or	ne, date and place pinion, death occu	, and due to the irred at the time,	cause(s) a	and manner as place, and due	stated. to the cause(s)
ro the within rough comple	Me	29b. Signature and ritle of certifie				290	. License	number		29d. Date	signed (Mgnt	h, Day, Year)
						7	5T	7028		3/	27/1	06
		30. Name and address of person	who completed cause of d	eath (Iten	п 23а) (Туре,	Print)		0	1 /	1	10	000
10		Haitya Chor	ora MIL	00 (	000 F	Kida	ely	Hive.7	7231 F	thro	polis	MUSHOL
Sta Regist		31. Date filed (Month, Day, Year)	32. Registr	s Signa	iture /K	die	AL D					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ For State Registrat Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 25, 2006 6:20AM March Norma Lee Greene /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Somerset Princess Anne 27279 Deal Island Road If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 M 2 KF Director 03/04/1930 Maryland 220-26-1025 Usual Residence of Decedent permit. Pages 1 and 2 should be flied within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumetic aven. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes 2√ No Director Princess Anne MD Somerset 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21853 USA 27279 Deal Island Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: þ 3⊠ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Insulation Business 12 owner/manager none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mabel Mason Edwin Price 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PO Box 104, Princess Anne, MD 21853 Kay Outten/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 03/28/2006 Princess Anne, MD Beechwood Cemetery ' 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home 2000 MO0295 11673 Somerset Ave., Princess Anne, MD 21853 2/a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) Chronic Obstructive Purmonary DIEDE **Physician** YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tres 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 1 Yes No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

or Attending Physicien: Diractor: After this in by the funeral within 24 hours a To the Funerel ( filled

29b. Signature and title of certifier

29a. Certifier

Medical

State

Registrar

29c. License number D36576

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Da

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 560 RIVERSIDE RAVITZ RONALD

32. Regis rar's Signature 1 2006

				1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of rtificate of			ene g. No: 006	1273
		Physic /Medi		Decedent's Name (First, Middle, Last)     Ru	ith G. Gre	esser			2. Date of Death Month March		3. Time of Death 8:55 A M
		Exami		4a. Facility Name (If not institution, give s Gilchrist Hospice				or Location of Death		4c. County of Deat	
		Funeral Director		5. Social Security Number 6. Sex 003 46 1787	7. Age	(In yrs. last birthday, Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Apr 16,	Year) 9. Birt Co 1957 Ne	hplace (State or Foreign untry) W York
		death with the Maryland me 23a or 28a-f ehow r must be mutified at	ector	10a. State 10b. County  MD Howard  10e. Street and Number		10c. City, Town or L	a				10d. Inside City Limits 1 ☐ Yes 2 🛂 No
An		3a or	io =	10706 Hunting Lane	<u>.</u>		10f. Zip Code 2104	44	10	g. Citizen of What Co United St	Ť
855Am	9800		by Funeral Director		2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	rican Indian,
te at	Baltimore, Maryland 21215-0036	permit. Peges 1 end 2 should be filed within 72 hours atter Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite any Injury or other treumatic event, the Medical Examina 90ce.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5- 5+	⊦) ///e.	dent's Usual Occu kind of work done DO NOT use retire	1		6b. Kind of Business/ Johns Hopk Physics La	ins Applied
200	and	d be fill	Be	17. Father's Name (First, Middle, Last) Rolland Schreib				18. Mother's Name Ruth Mel		aiden Sumame)	
0,	ary	should and Men marke	P <sub>C</sub>	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Stree			City or Town, State, Z	(ip Code)
3	S,	lend 2 fealth a fm 27 i		Mark Schreib/Broth	er	1931	7 Treadwa	ay Road Br	ookevill	e, MD 2083	33
ann 25, 2006	TOL	ent of H nt: If Its y or of		20a. Method of Disposition  1 ☐ Burial 2 ② Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of Disponsion Cemetery, cred		3-27-		oc. Location - City or T atonsville	
las	altii	permit. F Departmo Importar any Injur		21. Signature of Funeral Service License	-00						ily FH Inc.
5	8	80 = 9		Blem Collis	whe	4	112 Old (	Columbia P	ike Elli	cott City,	MD 21043
2	7	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line	consequence of):		ng, such as cardiac c	or respiratory arres	st,	Approximate Interval Between Onset and Death
Sut		Examiner	ilner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury		eur esquenes of).					0
SC.	8760,	icate be executed physicien and the burial-transit	dicai Examiner	cause (Disease of Injury that initiated events resulting in death) Last  d.	Due to (or as a	consequence of):					
Greg	O. Box 68	The law requires that the death certifica ate has been signed by the attending phage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome o 1 □Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetel death 3	Ectopic pregnance Other (specify)	у		23d. Date of deliver Month	very Day Year
	rds, P.	w requires that been signed by should be deta	ρ	Part II. Other significant conditions cont	ributing to death but	not resulting in the u	nderlying cause giv	ven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
	Division of Vital Records,	: The law re cate has bee , page 2 sho	Completed						24a. Was an autopsy performe	prior to co	opsy findings available ompletion of cause of 2 No
	VIE E	Physicien: Th r this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ◯ No	spital:	a∏50/0 · · ·	3 DOA O#	26. Place of Death			11
	ion of	af e	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 28a. Date of Injury (Month, Day)		28c. Injur	4 🗀 Nuising Hon	ne 5 🗌 Residend 8d. Describe how		ty) - ospice
	Divis	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc.				City or Town, .		
		Hosp 24 hou Fune etely fil	edicai	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of er: On the basis of e and manner state	ixamination and/or inv	occurred at the tirestigation, in my o	me, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as :	stated. to the cause(s)
•		To the within To the comple	Me	29b. Signature and title of certifier  Markhure	7 Rile		29c. Licens		29d	. Date signed (Month,	Day, Year)
	0	02		30. Name and address of person who com	pleted cause of the	th (Item 23a) (Type,	Chroles	St. Ba	lto. mo	Arch 25	ķ
		Sta Registra		31. Date filed (Month, Day, Year)	32. Registrar	-	(				

AEM 06-02101 Thoma

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

as		s F	lairston <b>1-</b> State Registrar	State of Maryland		artment of F		•	giene	006	1274
	, , , , , , , , , , , , , , , , , , ,	*	1. Decedent's Name (First, Middle, Last,					2. Date of De	ath Day	Year	3. Time of Death
	Physici /Medio		Thomas Julius	Hairston				March	-	2006	11:04 P M
7	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of De			ounty of Death	
	Funeral Director		1420 Jefferson Str 5. Social Security Number 6. Sec 227-32-9826		st birthday) Yrs.	Hyatts If Under 1 Year Months Days	If Under 24 H		pth Year) 1930	rince ( 9. Birth Coul 0 Vir	George's polace (State or Foreign ntry) ginia
	filed within 72 hours after death with the Maryland Hygiene, withen "naturel", or items 23e or 28e-f ehow ant, the Medical Examinant must be notified at		10a. State 10b. County	,	Town or Lo	cation					10d. Inside City Limits
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural; or Items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinat must be notified at other.	tor	MD Prince	Georges Hya	ttsv	ille					1X Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citize	on of What Cou	ntry?
	15 will		1420 Jefferson	Street		20782			U. S	S.A.	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. \	Vas Decedent of H	lispanic Origin?	(Specify Yes or No erto Rican, etc.)	)- 14	Race - Americ	
9	or it		1 ☐ Never Married 2 ☐ Married	1 Yes 2 □ No If Yes, Give		I □ Yes 2 ☐ No		ono moan, etc.,		pecify: Bla	_
ë	ural',	d by	3 Widowed 4 Divorced	Year or Dates:					3	рвспу. В 1 а	
<u>ν</u>	nati	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Deced (Give	lent's Usual Occup kind of work done DD NOT use retired	pation during most of v	vorking	16b. Kind	of Business/In	dustry
2	Mithing Then	dH	Elementary/Secondary (0-12)	College (1-4or 5+)		DD NOT use retire: rvisor	d)		Gove	erment	
2	Hygie ther nt, II	ပ္ပ	1 2 17. Father's Name (First, Middle, Last)		•		19 Mothare A	lame (First, Middle,	Maidan S		
ä	ntai ed o	Be	John Thomas Hai:	reton				Emma Mu:		umame)	
2	should be and Mental I marked o	မ	19a. Informant's Name/Relationship (Ty		19h Mailin	a Address (Street		Rural Route Number		Form Chata Tie	0-41
<u>≅</u>	id 2 s ith an ith an trau		Pearl T. Hairst					.Hyatts			
Baltimore, Maryland 21215-0036	Hear Hear tsm (		20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of		Date		ition - City or To	-
2	y or		ty☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emova: from State		atory or other place	· 1	/01/06		•	
	artme ortan injur		21. Signature of Funeral Service License					aylor's			
ä	Depa Impo any i		1 RP Th	1000				•			DC 20001
1	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	Due to (or as a consequent	OW nce of):	OX FOE		ac or respiratory ar	rrest,		Approximate Interval Between Onset and Death
	ured ansit	ᇤ									
3/60,	ate be hysicia the bur	dical Examiner	resulting in death) Last	Due to (or as a consequent	nce of):						
٥	ing p	Med	IF FEMALE:	V 5 - 7 10 / 11 / 7 F / 2							
O. Box	at the ettending p by the ettending p tached for use as i	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnanc 1 Live birth 2 Fetel de 4 Pregnant at time of deat 9 Unknown	eath 3	Ectopic pregnancy Other (specify)	′		230	d. Date of delive Month	ery Day Year
<b>7</b>	igned b		Part II. Other significant conditions con	tributing to death but not resulti	ng in the un	derlying cause giv	en in Part I.	23e. Did to	obacco use	contribute to th	ne cause of death?
rds,	aw requires that the es been signed by the 2 should be detached.	d by						101	res 2 🖼	No 3□Prob	ably 4 Unknown
Vital Record	been si should I	Completed						24a. Was	an a	24h Were auto	psy findings available
e j	ate hes	Ĕ						autop	rmed?	prior to cor	npletion of cause of
<u>a</u>	certificat	ပိ	25. Was case referred to medical				OC Place of D		2 No	1 T Yes	2 No
>	y socialis is certific director,	0 0	examiner? 1, Yes 2 □ No	ospital: 1 ☐ Inpatient 2 ☐ EP	VOutnatient	3□ DOA Oth		eath <i>Check only</i> of Home 5 Resid		Other (Case)	10
0	After th	Ë	27. Manner of Death		3b. Time of	28c. Injun Worl	y at	28d. Describe h			"Scene
DIVISION	tor: Aft the fun	Certification:	1 ☐ Natural 5 ☐ Pending 2 ☑ Accident investigation		1000 1000		Yes 2 No	Sunsie	ser A	SPIRAT	ero on food
<u> </u>	er de	E 1	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	3 4			28f. Location (S City or Tow	Street and N	Number or Rura	l Route Number,
5 }	rs aft rs aft iei Di	Cer			LOME		.1			W ST P-40	DRY 3 > CO MM
2	within 24 hours after death, within 24 hours after death, To the Funeral Director: After this certifical completely filled in by the funeral director, i	edical	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Exemin	icien: To the best of my knowle er: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tin estigation, in my o	ne, date and pla- pinion, death oc	ce, and due to the o	cause(s) an	d manner as st	ated
1	within To the complex	Me	29b. Signature and title of certifier	- State a		29c. License	e number		29d. Date s	signed (Month, I	Day, Year)
) [			1 doubries 1	Malerio		00	'ME'				
: 1	(5)	-	30. Name and addres of person who co	mpleted cause of death (Item 23	За) (Туре, Р		CME		march	26, 20	JU6
<u>ار</u>	9		MARYDERTS D.	KOREU		111 Per	n_Stree	t Baltimo	ore. M	Marvlano	1 21201
100	Stat	P	31. Date filed (Month, Day, Year)	2. Registrar's Signature	-						

Registrar DHMH 17 Rev 1/2001 MAR 2 9 2006 Scare & Sparle

			1 - For State Registrar	State of Ma	aryland		artment of F rtificate of			Reg. No.	U U O	11275
	Physici /Medic		1. Decedent's Name (First, Middle, Las Carmel		Hall	eck			2. Date of De March		<sup>y</sup> 2006 <sup>Yeer</sup>	3. Time of Death 7:29P M
	Examin		4a. Facility Name (If not institution, give Southern Maryland				4b. City, Town, o	r Location of Deat N	h	1	County of Death	orge's
.3	Funeral Director		010 11 101	ex 7. Age □ M 2☐, F 84	o (In yrs. ias	t birthday) Yrs.	ff Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da			place (State or Foreign ntry) achusetts
	/land		Usuaf Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation					IOd. Inside City Limits
	e Man	Director	Maryland Prince G	eorge's	Oxon	Hill						1 ☐ Yes 2 🕅 No
	with the or 20		10e. Street and Number 5813 Galloway Dr				10f. Zip Code 20745				izen of What Coul	ntry?
	death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13.	Was Decedent of H	lispanic Origin? (S	pecify Yes or No	US 	14. Race - Americ	
0000	s 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. Item 27 is marked other then "natural, or items 23a or 28e-f ehow other traumatic event, the Madical Establish in the indilling at	þ	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 N N If Yes, Give Year or Dates:	lo		1 ☐ Yes 21 No	Specify:	to rican, etc.)		Black, White, Specify: Whi	
2	n 72 h	letec	15. Decedent's Ec (Specify only highest gra	de completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wo	rking	16b. Ki	ind of Business/In	dustry
7 7	d withingiene.	Completed	Elementary/Secondary (0-12) 8th	College (1-4or 5	·	Homer				Own	n Home	
aud	be file ital Hyg id othe event,	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nac	me (First, Middle Cangelo		Sumame)	
Z	2 should be filed win and Mental Hygien is marked other th raumatic event, Ita	၉	Giovanni Trave			19b. Maili	ng Address (Street				or Town, State, Zin	Code)
Ma	l and 2 s lealth ar im 27 is her trau		Walter F. Halleck				Galloway					,
o e	Pages 1 and nent of He ant: If Item		20a. Method of Disposition 1XXBuriat 2 ☐ Cremation 3 ☐	Removal from State	20b. Plac	ce of Dispo netery, crea	sition (Name of matory or other place	ce)	Date		ocation - City or To	own, State
Daltimor	글로로를 .		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer		Ceda	r Hil	1 Cemete	ry 3/30	0/06	Sui	tland, M	D.
Ö	Depa impo any i		In 8. Kar	10 m		61	.60 0xon	Hill Rd.	Oxon Hil	11as 1, M	runerai Id. 20745	ноте
ı			23a. Part1. Enter the disease, or com shock, or heart failure. List only	pfications that caused one cause on each fin	the death. ie.	Do not ent	er the mode of dyin	ng, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician /Medical		frimediate Cause (Finat disease or condition resulting in death)	a Atria	-1 F	1 61	llatio	<u></u>				Youths
	Examiner			Due to (or as a	a conseque	nce of):	llatio.	Nisea	50			Years
1/2	sit ad	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a conseque	nce of):			-			
	avecute al-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as a	a conseque	nce of):						
00/00	ificate be executed g physician and as the burial-transit	edicai	(	d								
7.	certifica nding pt use as tl	/Med	IF FEMALE:	23c. If yes, outcome	of pregnanc						201 5	
.c.	death e atter	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ❤️No 9 ☐ Unknown	1☐Live birth 4☐Pregnant at 9☐Unknown	2 Fetat d	eath 3[	Ectopic pregnancy Other (specify)	<i>'</i>			23d. Date of delive Month	Day Year
Z.	requires that the een signed by th hould be detache	by Pr	Part II. Other significant conditions of	ontributing to death bu	ut not result	ing in the u	nderlying cause giv	ren in Part f.	23e. Did t	obacco u	use contribute to t	he cause of death?
coras,	require								-		□No 3 □ Prot	pably 4 Minknown
nec T	: The law icate hes b ; page 2 sl	Completed							24a. Was auto perfe 1 Yes	psy ormed?	prior to co death?	opsy findings available impletion of cause of
\	s certif	o Be	25. Was case referred to medicat examiner? 1 ☐ Yes 2 > No	Hospital: 1 Minpatie	nt 2∏El	R/Outpatier	nt 3 DOA Oth	26. Place of Deler: 4 Nursing F	ath <i>(Check only o</i>	/	5 □Other /Specii	(v)
io Ho	nding Phy th. :: After thi	-	27. Manner of Death  1 Manual 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	y 2	8b. Time o Injury	f 28c. Injur Wor		28d. Describe			,
DIVISION	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not by determined	28e. Place of Injubulding, etc	ury - At hom c. (Specify)	e, farm, st	reet, factory, office		28f. Location ( City or To		nd Number or Rura	al Route Number,
	he Hospit n 24 hour he Funera	edical (		ysician: To the best on ninar: On the basis of and manner sta	examinatio							
	To t Withi To t	Σ	29b. Signature and title of certified	Pulled	2.D	0	29c. Licens	e number	145		te signed (Month,	
) _	(6)		30. Name and address of person who	completed cause of de	eath (Item 2	3a) (Type,	Print) MICH	HAEL P	MENTE	EL, I		, 2000
B	Sta	to	601 POST OFFIC 31. Date filed (Month, Day, Year)	2 Registra	r's Signatu	re		E, M.	2060	2		
1	Registr		MAR 2 8 200		k	400	de					

			For State	State of Maryland	•	irtment of H			jiene	11276		
			Registrar  1. Decedent's Name (First, Middle, Last)			imouto or i		2 Date of Deal		3. Time of Death		
	Physici	an	Helen	Virginia	Hom 1 d	n-McKee		Month MATEGORE	Day Year			
	/Medic		4a. Facility Name (If not institution, give s		папті		Location of Death		27TH, 2006			
	Examin	er	, , ,	11 001 41.0 11.001/				,	ALLEGAN			
			MEMORIAL HOSPITAL  5. Social Security Number 6. Sex	7. Age (In yrs. Ia	ast birthday)	CUMBERL If Under 1 Year		8. Date of Birth	9 B	rthplace (State or Foreign		
	Funeral Director			IM 2⊠F 89	Yrs.	Months Days	Hours Min.	(Month, Day)	(Year)	Country)		
			Usual Residence of Decedent					10//00/1	910   Ma	ryland		
	yland		10a. State 10b. County	10c. City	, Town or Lo	cation	,			10d. Inside City Limits		
	Many fet	ţ	MD Alleg	any	Cum	berland				17 Yes 2 □ No		
	1 the	Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of What (	Country?		
	within 72 hours after death with the Maryland ene. then "natural", or Itema 23a or 28a-f ehow the Madical Examinar must be mullified at		1428 Dogwood C	ourt		2	21502		USA			
	ms 2	Funeral		12. Was Decedent Ever in U.S	S. 13. V	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S	pecify Yes or No-	14. Race - An	erican Indian,		
	rite	Fur	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				o Rican, etc.)		ite, etc.		
<u>ම</u>	urs a	þ	3 X Widowed 4 ☐ Divorced	If Yes, Give 1 Year or Dates:		□Yes 2X No	Specity:		Specify:	hite		
Ŗ	2 ho	Completed	15. Decedent's Educ (Specify only highest grade	cation (start)	16a. Deced	lent's Usual Occupa	ation	ting	16b. Kind of Busines	s/Industry		
2	nin 7	pie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	)	Amy				
2	d wit	Ö	6		Nu	rse Aid			Hospital			
힏	oth vent	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, i	Maiden Sumame)			
<u>a</u>	Alenta Alenta rked tlc •	P P	Joseph	Edward	Hou	se	Rose	F	Prout			
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural, or Itema 23a or 28a-f show appring to other treumatic event, the Madical Examilitar must be nutilised at once.		19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mailin	g Address (Street a	and Number or Ru	ral Route Number	r, City or Town, State	Zip Code)		
	alth alth 27 l		Mary Minnick / ni	ece	1131	O Sunny I	Lane, NE.	, Cumber	rland, MD	21502		
altimore,	if He other		20a. Method of Disposition	Ca	lace of Dispo	sition (Name of natory or other place	a)	Date	20c. Location - City of	r Town, State		
٤	Page ent o nt: If ry or		NXBurial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation—5 ☐ Other (Specify)	emoval from State				3/30/2006	6 Cumberl	and MD		
₹	artm ortai		21. Signatur of Funeral Service License							1 Home, P.A.		
ä	Per Per Per Per Per Per Per Per Per Per		X11. 2/8	1					land, MD	21502		
			23a. Part1. Enter the disease, or compli	cations that caused the death						Approximate		
	-		shock, or heart failure. List only or Immediate Cause (Final							Interval Between Onset and Death		
	Physician /Medical		disease or condition resulting in death)	CARDIOMYOPATH					5 YEARS			
	Examiner		f 2.	Due to (or as a consequ	ience of):							
		-	Sequentially list conditions,	Dua to (or se a consequ	iurau ufir							
	ted nsit	Examiner	Sequentially list conditions, if any, isading to immediate cause. Enter Underlying Cause (Disease or injury									
	and and II-trai	xar	that initiated events resulting in death) Last	Due to (or as a consequ	ence of):							
8760	cate be executed physicien and the burial-transit				,							
	phys the	dicai		•								
9 ×	The law requires that the death certificate has been signed by the attending itsee 2 should be detached for use as	/Me	IF FEMALE:	3c. If yes, outcome of pregnar	nev				02d Date of d	a linear e		
Division of Vital Records, P.O. Box	atten for u	Physician/M	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of d Month	Day Year		
o	the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	atti 5	Other (specify)						
۵.	that t	F.	Part II. Other significant conditions con	tributing to death but not resu	ulting in the ur	nderlying cause give	an in Part I.	23e. Did to	bacco use contribute	to the cause of death?		
က်	w requires that been signed I should be det	by	•	•	•	, <b>,,</b>		1□ Y	es 2□No 3□	Probably 4 🔀 Unknown		
Ö	requ houk	etec						-				
ec	has t	hdu						24a. Was a autops	sy prior to	autopsy findings available completion of cause of		
=	The cate	Completed						perfori 1 ☐ Yes		s 2 No		
/Ita	Attending Physician: The rideath. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?			7.4		th (Check only or	76/			
=	Physic this c	မ			ER/Outpatien		4 🗆 Nursing n		ence 6 □Other (Sp	ecify)		
2	ding P. h. After t	Certification:	27. Manner of Death  1   Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun Work		28d. Describe ho	ow injury occurred			
<u> </u>	eath.	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 []	Yes 2 □ No					
$\geq$	irect Irect	ŧ	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hos building, etc. (Specify)		eet, factory, office		28f. Location (Si City or Town	treet and Number or i n, State)	Rural Route Number,		
Ω	irs af											
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical Examin	sician: To the best of my know ner: On the basis of examinati	wledge, death	occurred at the time	ne, date and place pinion, death occu	, and due to the c	ause(s) and manner late and place, and di	as stated. ue to the cause(s)		
	within 24	led	one)	and manner stated.								
		Σ	29b. Signature and title of certifier	1		29c. License	19amun e		29d. Date signed (Mo			
)	3		1/ilh	7-1		D.	36766		March.	11000		
	100		30. Name and address of person who co	mpleted cause of death (Item	23а) (Туре,	Print)						
	MRS		POONAI, VIKRAMADIT	YA, M.D., 924	SETON	DRIVE,	CUMBERLAI	ND, MD 2	1502			
	Sta		31. Date filed (Month, Day, Year) MAR 2 9 20	32. Registrar's Signat	ture	locall &						
	Registr	ar	MHU C 2 50	UU STATES	150° 180	The state of the s						

Amended #16a, nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 03/27/06, Allegany Co. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** AULT 2006 HOOVER MARCH 23, 1:15 AUDREY Ε. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ALLEGANY CUMBERLAND COUNTRY HOUSE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Wonths Days Hours Min. JUNE 21, 10 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** 1 ☐ M 2127 F MARYLAND 86 Yrs Director 220-10-4934 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State other than "natural", or Itams 23s or 28s-f ahov rent, the Modical Examiner must be notified at 1X7Yes 2□No ALLEGANY CUMBERLAND Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 546 GREENE STREET U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of w life. DO NOT use retired Nursing g most of working Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY & NIRSING ASSISTANT HOSPITAL 12 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Heelih and Mental Hy Important: If Itam 27 is marked othin any liquiry or other traumatic avent, SIRS. 17. Father's Name (First, Middle, Last) Be ROY SNYDER REGINA MAE NULL 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOHN WESLEY AULT / SON 6448 SKIPTON DRIVE, HANOVER, MD 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State FLINTSTONE, MD M.S.V.C.-ROCKY GAP 4 ☐ Donation 5 ☐ Other (Specify) 03/27/2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility UPCHURCH FUNERAL HOME, P.A. 202 GREENE STREET, CUMBERLAND, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21502 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vascula ere **Physician** DVO /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): physicien are as the burial-t Division of Vital Records, P.O. Box 68760 by Physician/Medical ettending p 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 ☐ Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2 No : After this certifical funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Assisted Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: To the Hospitel or Attanding I within 24 hours efter death. To the Funeral Diractor: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of carrier rel 24 2006 DOU 33280 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland, MID Stanil Grapta, 31. Date filed (Month, Day, Year) 625 Kent 32. Registrar's Signature Ave.

DHMH 17 Rev 1/2001

State

Registrar

MAR 27

2006

Amended Item 1 per Physician 03/28/2006 Carroll County, wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 22 2006 **Physician** DIRV MADIE HAWKING HAWKINS RUBY MEREE MARCH 5:20 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 26, 1925 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 M 2 XF Virginia Director 220-22-0678 80 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or itama 23a or 28a-f show other traumatic event, the Madical Examinar mout be notilised at 10d. Inside City Limits Frederick Keymar 1 Yes 2 No Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 11905 Renner Rd. 21757 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Tes 2 No þ Specify Specify: 3 XWidowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "reany njury or other traumatic event, the Macd once. Elementary/Secondary (0-12) Colfege (1-4or 5+) assembly line worker air conditioning mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be William Rush 2 Pearl Elizabeth Rosenbaum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheldon Hawkins Jr./ son 11905 Renner Rd. Keymar, MD 21757 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Haugh's Cemetery 3/25/2006 Ladiesburg, MD 21. Sign were of Fineral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home athans 404 S. Main St. Woodsboro, MD 21798 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onet and Death fmmediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a Examiner Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a col Examine equence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Oate of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign. 2. No 3 Probably 4 Unknown Completed 1 ☐ Yes 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2/No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 1 > patient 2 ER/Outpatient 3 DOA After thi funeral 28b. Time of 28c. Injury at Work? Medical Certification: 27. Mannet of Death 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No the hours after deat 3 Suicide 6 Could not be in by t 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

A dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie

State Registrar

3

DHMH 17 Rev 1/2001

To the Hospital or Attending Physician; The law requires that the death certificate be executed

death.

Division of Vital Records, P.O. Box 68760

the Maryland

death y

72 hours after

Baltimore, Maryland 21215-0036

29b. Signature and title of certifier

31. Date filed (Month, Day,

Name

who completed cause of death (item 23a) (Type,

29d. Date signed (Month, Day, Year)

			1 - State Registrar	State of Marylar			nt of He te of D		R	eg: No.U U	6	11279
	Physici	an	Decedent's Name (First, Middle, Last)						Date of Deat     Month	h Day	Year	3. Time of Death
1	/Medic	al	Mary V. Horsey			44 03	T	CD t	March		00 G	△ 600 M
7	Examir	er	4a. Facility Name (If not institution, give s.  PENINSULA REGIONAL		West.	4b. City		ocation of Death		4c. County	or Death	100
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)		r 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthp	place (State or Foreign
	Director		102-14-3841	M 2X F 83	Yrs.	Months	Days	Hours Min.	8-19-19	2 <sup>Year)</sup>	Cour	DE.
	pu ,		Usual Residence of Decedent	10- 0								Other Limite
	aryla •hov	2	10a. State 10b. County		ty, Town or Lo	cation					'	0d. Inside City Limits  X☐ Yes 2☐ No
	the M	Director	DE. Sussex		Laure1	104 7	p Code		1	0g. Citizen of W	/bat Cour	
	with	급	103 Brooklyn Ave.				19956		'	USA	mai Coui	щуг
	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow the Madical Exar Iran must be twittled at	Funerai	<u>.</u>	2. Was Decedent Ever in U	.S. 13.1			panic Origin? (Sp , Mexican, Puerto	ecify Yes or No-			can Indian,
9	or ite	Für	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 No If Yes, Give		it Yes, sp 1 □ Yes		, Mexican, Puerto Specify:	Hican, etc.)		k, White,	
21215-0036	ours	d by	3 Widowed 4 □ Divorced	Year or Dates:		103	4EJ NO	эреспу.			Whi	
5	"nati	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	dent's Us kind of w	ual Occupat ork done du	ion uring most of work	ing	16b. Kind of Bu	siness/In	dustry
2	withii 906. Then	dmc	Elementary/Secondary (0-12)	College (1-4or 5+)				n & sale		Furnitu	re S	tore
b	Hyg other	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Nam		Maiden Surnam	e)	
lar	uld be Aenta rked tic ev	To B	Edwin Stearns Val	Liant				Pauline	Hearne	Registe	r	
Maryland	2 sho and h le ma		19a. Informant's Name/Relationship (Typ			-	•	nd Number or Rur				Code)
≥ ′	and sealth m 27		Faith English, Day		_2			1 Rd. He				
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or items 23a or 28a-1 ehow any injury or other traumatic event, the Marical Exactivations to the traumatic event, the Marical Exactivations to the traumatic event.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	Place of Dispo cemetery, crer Fello	natory or	ime of other place) om	4-1-		20c. Location - Laure1,		own, State
≣	it. Pa		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License				and Address	-		naurer,		
Ba	Depa Impo		HOOD - Short-	Hamina	H	anni	gan Sl	hort Dis	haroon F	uneral	Home	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the deat	h. Do not ent	er the mo	est Si de of dying,	t. Laure such as cardiac	or respiratory arr	9936 est,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	A C P	110							Onset and Death
F.	/Medical Examiner		resulting in death)	Due to (or as a consec	uence of):							
			Sequentially list conditions, b.									
	be sit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons⊯	uence of):							
•	xecut and al-tran	хап	that initiated events c. resulting in death) Last	Due to (or as a consec	uence of):						-	
68760,	ficate be executed physicien and s the burial-transit	alE	4									
_		ledical	_ u.									
Box	th cert endin r use	M/us	230. Was decedent pregnant	ic. If yes, outcome of pregna 1 Live birth 2 Feta		3Ectonic	pregnancy			23d. Date		*
П	e dea he att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of c		Other (s				Mor	าเท	Day Year
P. O.	hat the d by t detach	Phy	9 ☐ Unknown  Part II. Other significant conditions con	ributing to death but not res	culting in the u	ndorhina	cause awar	in Dart I	23e Did tol	nacco use contr	ibute to t	he cause of death?
ds,	The law requires that the death certil Ne has been signed by the attending page 2 should be detached for use a	1 by	Knul Foul	And the second s	umig in the u	noenying	cause giver	iliralii.			3 ☐ Prob	N
Š	r requ	etec	70.000						24a. Was a			
Rec	2 5 2	Completed							autops	ped? d	rior to co leath?	psy findings available mpletion of cause of
ā	in: Th	e Co	25. Was case referred to medical			7 12 2 2		26. Place of Deat	1		☐ Yes	2 No
5	ysicia s cert direct	To B	examiner?	ospital: 1 XInpatient 2 [	ER/Outpatier	nt 3 🗆 🗆	Other		me 5 Reside		er (Specif	
סר	g Phy ter thi		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injury a Work?	A STATE OF THE STA	28d. Describe ho			,,
Ö	Attending Physician: It death. ector: After this certifics by the funeral director, p	atio	1 Natural 5 Pending investigation	(Month, Say roas)	підату	М		es 2□No				
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, str fy)	eet, facto	ry, office		28f. Location (Si City or Town		er or Rura	al Route Number,
	To the Hospital or Attending Physician: The i within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1 Certifying Phys	inian. To the heat of any local	aulodao dasii	h occurre	d at the rise	data and ata-	and due to the	aven(c) as 1		tatad
	To the Hospital within 24 hours a To the Funeral I completely filled	edicai		icien: To the best of my known; er: On the basis of examination and manner stated.								
	ro the vithin rough	Me	29b. Signature and title of certifier	1		2	c. License	number	2	9d. Date signed	i (Month,	Day, Year)
	103		DE Chris	up		1	20	9 12		3/2	8/0	(
,	Sa		30. Name and ddress of person who con	npleted cause of death (Iter	m 23a) (Type,	Print)		7/4			1	- ingre-
	1,		Denois Chodnick	npleted cause of death (Iter	resoll	5%	Sal	isbury	MO .	21801		CPOPE TO SERVICE STATE OF THE
	Sta		31. Date filed (Month, Day, Year)  MAR 2 9 20	32. Registrar's Signa	ature	10						

State of Maryland / Department of Health and Mental Hygiene

1	- [	0	0	0
		6	O	Ł

					Certificate of	Death	Re	g. No.	) !	12.00
			1. Decedent's Name (First, Middle,				2. Dete of Death	Dey p	Year	3. Time of Death
	Physician /Modica		ILOW RUT	H HARRI	NGTON		Month ~	17-20	206	6:10 am
	/Medica Examine		4e Fecility Neme (If not institution, g	ive street end number)		4b. City, Town, or Lo	cation of Deeth	4c. County	of Deeth	
1		ı	HEARTFEILDS	CF ENSTON		EAST	ON	TAL	-BO	Τ
	Funeral	-	5. Social Security Number 6	Sex 7. Age (In yi	rs. lest birthday) If Under 1 Yea  Months Days		8. Date of Birth (Month, Dey,	Yeer)	9. Birthpl Coun	lace (Stete or Foreign try)
	Director		504-20-1465	8	S Yrs.		SEPTIL	1925	TH	DIANA
. –	pu *	- H	Usuel Residence of Decedent  10a. Stete 10b. County	10c.	City, Town or Location			<u></u>	10	Od. Inside City Limits
	lanyle sho		N-N-		EASTON					12 Yes 2□No
	28a-	3	MD TALBO		10f. Zip Code		10	g. Citizen of W	/het Coun	trv?
	with with	3	1		2160	71		ixn		
	ifier death with the Mar r items 23a or 28a-f si niner must be notified		100 PORT ST	12. Was Decedent Ever in	U.S. 13. Was Decedent of	ل ( Hispe <i>n</i> ic Origin? (Spe	ocify Yes or No-	14. Race	- Americ	an Indian,
10	ter d		1 Never Married 2 Married	Armed Forces?,	It Yes, specify Cu	ban, Mexican, Puerto	Rican, etc.)		k, White,	etc.
336	or le	2	3 (¥Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Yes 2 □ N	Specify:		Specify.	WI	HITE
21215-0036	within 72 hours effer death with the Marylend ene. then "natural", or ferms 23s or 28s-f show the Medical Examiner must be notified at	Completed by	15. Decedent's	Education	16a. Decedent's Usual Occu (Give kind of work don	ipation	ing 1	6b. Kind of Bu	siness/Inc	Justry
218	hin 7	2	(Specify only highest s Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retir	ed)	,,y			
21	d will	Ę		2	HOTEL GWY	IER		HOTEL		OTEL
р	be filed d other event, the	9	17. Father's Neme (First, Middle, La	st)		18. Mother's Name	10-1		е)	
<u>yla</u>	should be filed with and Mentel Hyglene. I marked other than umatic event, the N	2	ENOS WIL	30 N		IDA	A PEA	1 10		
Maryland	2 sho end is me	3	19a. Informant's Name/Relationship		19b. Mailing Address (Street	et and Number or Run	al Route Number,	City or Town,	Stete, Zip	Code)
	end ealth m 27	-	WILLIAM HAM		Place of Disposition (Name of	21 0660	Date 2	Oc. Location -	City or To	495
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Depertment of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at page.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removal from State	cemetery, crematory or other pi	,				
Ë	men tant: jury		4 Donation 5 Other (Spe		URner's Ceme	TERY IS	1_2006-1	MANT	TICE	->m0
3al	Depenti Depenti Importu any inj		21. Signature of Funeral Service Lic	ensee /	22. Name and Add	ress of Fecility  K FUNET	al Hom	TE 12	) BO	X61
,	00 = 6 a		Cottens to	sick of moor	HAJEST GIL	CAR! IL	1001	21-1		
			23a. Pert1. Enter the disease, or co shock, or heart failure. List or	mplications that caused the de ly one cause on each line.	eath. Do not enter the mode of dy	ving, such as cardiac o	or respiratory erre	st,	1	Approximate Interval Between Onset and Death
	Physician								1	Origon and Dough
1	/Medical Examiner		Immediate Cause (Finel disease or condition resulting in death)	e. End Sta	ge Alzheimer	15				5 years
н		<u>.</u>		Due to	(or es e consequence of):					
1	ertificete be executed ling physician end es the bunel-trensit			b	/					
`_`	ires that the death certificate be executed signed by the ettending physician and d be deteched for use as the buriel-transit	X	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying	Due to	o (or es e consequence of):					
68760,	ertificete be exe	200	Cause (Diseese or injury that initiated events	cDue to	(or as e consequence of):					
89	g phy g phy es th	2	resulting in death) Last	-33	(				1	
Box				d					1	
	deet deet od fo	3	Part II. Other significant conditions	contributing to death but not a	resulting in the underlying cause (	given in Part I.	23b. Did tot	Dacco use cor	ntribute to	the cause of death?
P.0	requires thet the deeth creen signed by the ettencreen signed by the ettencreed for us	Dy Fillysician					1 □ Ye	8 2 DNO	3 Prol	bably 4 ☐ Unknown
	es the	2								A Air Air
ord	v require been si should	9					24a. Wes en	eutopsy ed?	av	ere autopsy tindings ailable prior to mpletion of cause
Records,	98 b 2 s 2 s	2							of	deeth?
	ate h	Completed					1□ Ye	s 2 No	1[	☐ Yes 2☐ No
/ita	ysicien: The levision of the second of the s	9	25. Wes case referred to medical examiner?	Hospital			h (Check only one			
of Vital	Physician: this certific rel director,	2	1 ☐ Yes 2 ☐ No  27. Menner of Deeth		ER/Outpetient 3 DOA	4 U Nursing Ho	me 5 Aeside 28d. Describe ho			γ)
L C	Ilng F		1 ☑Naturel 5 ☐ Pending	28e. Date of Injury (Month, Dey Year	28b. Time of 28c. In W	ork? □ Yes 2 □ No	200. 2000,120 710	,a., oaca		
Sic	death death tor: / the	2	3 ☐ Suicide 6 ☐ Could no	be con Black of Injury A	t home, farm, street, factory, offic		28f. Location (Str	reet end Numb	er or Rura	al Route Number,
Division	or A effer Direct	Certification:	4 Homicide determin	building, etc. (Spe	ecify)		City or Town	, Stete)		
	To the Hospital or Attending Phys within 24 hours efter death. To the Funeral Director: After this completely filled in by the funeral director.	2	29a. Certifier 1 Certifying	Physician: To the best of my l	nowledge, death occurred at the	time, date end place,	end due to the ce	use(s) end ma	nner es s	tated.
	Ho Ho	edicai	(Check only 2 Medical Ex	aminer: On the besis of exam end manner stated.	ination end/or investigation, in my	opinion, death occur	red et the time, da	ite and place,	and due to	) (ne cause(s)
	Within To the Comp	E	29b. Signeture end title of certifier	1		nse number	29	d. Date signe	1	-
			Delle Wil	N, m D	DO	646274		3/22	12006	
	^		30. Neme end eddress of person wi	o completed cause of death (I	tem 23e) (Type, Print)	400				
_	10		ALLEN WERE IND 31. Date filed (Month, Dey, Year)  APR 1 1	3579 Commerc	e DR 34112/06	chsten, mid	21601			
	State		31. Date filed (Month, Dey, Year)	2006 32. Régistrer's Si	gnatules (Special)					
	Registra	r	APR 1 1	COOO CONTRACTOR						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Shirley Halteman 2006 April 5:55 A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 14547 National Pike Clear Spring Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 □ M 2 💢 F 44 Yrs. Director 219-04-9744 April 19 1961 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County works or than "naturel", or items 23a or 28e-f shov the Medical Examiner must be notified at 1 Yes 2 No Director MD. Washington Clear Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14547 National Pike 21722 U.S.A. by Funeral death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give filed within 72 hours after 1 Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mennonite Home Assistant/Aid 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be and Mental is marked Gerald H. Halteman Margaret Strite ္ရ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health a Gerald H. Halteman/Father 14547 National Pike Clear Spring, Md. 21722 or other 20b. Place of Disposition (Name of cemejay, crematory or other place)
Stoutier's Mennnonite
Church Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Importent: If any injury or once. Smithsburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 4/6/06 22. Name and Address of Facility
Zimmerman And Son Funeral Home Inc.
45 S. Carlisle St. Greencastle, Pa. 17225 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician LOIA Non disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, tarry, leading to infried to cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examin To the Hospitel or Attending Physician: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician the burial by Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 🖔 No signed by the a 9 Naknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 X/10 3 ☐ Probably 4 ☐Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 5 esidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ္ရ 1 ☐ Yes 2 No this 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: / 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide in by 4 | Homicide within 24 hours after To the Funeral Direct 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Registrar DHMH 17 Rev 1/2001

State

completely

(Check only one)

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 2006

WI

32 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

tageratown, mp 21740

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 282 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Pay 2006 **Physician** 11:52 p M Edward Samuel Howard /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner Westminster Nursing & Rehab Ctr. Westminster Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Dec. 23, 1944 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Months Mary land 1**☑** M 2□ F 213-09-3071 61 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location item 27 is marked other than "naturel", or Ifams 23a or 28a-f show other traumatic event, the Madical Examina must be notified at Carroll Westminster 1 XYes 2 No Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1234 Washington Rd. 21157 USA death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 28 No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) None None None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) th and Mental h Be 1 and 2 should be Carl Saltan Howard Mary Catherine Bocklage ဂ္ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ant: If item 27 li Carl A. Howard/brother 4867 Millers Station Rd., Hampstead, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State ö Department Important: If any injury or Smithsburg Crematory Apr. 5, 2006 | Smithsburg, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Skiles Funeral Home 21. Signature of Fuperal Service License M00534 Beles 136 E. Baltimore St., Taneytown, MD 21787 23a. P411. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death **Physician** muse disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner nding physician and use as the burial-transit perlensin Due to (or as a consequence of) P.O. Box 68760. certificate be Physician/Medical IF FEMALE USB 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year ŏ 4☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown been si Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b lirector, page 2 s To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 A Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this Sep. 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t funera Certification: 1 ANatural 5 Pending investigation 1 Yes 2 No death. 2 Accident Director 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifies cause of death (Item 23a) (Type, Print) 2

DHMH 17 Rev 1/2001

State

Registrar

Ohn W.

31. Date filed (Month, Day, Year)

APR 1 1 2006

Registrar's Signature

Poole

			1 - For State Registrar	State of M	aryland		artmen <i>tificate</i>			and M		iene	6	11283
	Physici /Medic	al	1. Decedent's Name (First, Middle, Last  LHAN LOT	TE F	-	HO	VSe			Ł	2. Date of Deat	Day Z Y	Year 6	3. Time of Death  \$\mathcal{F} \cdot \mathcal{30} \mathcal{A}^{M}\$
	Examin	er	4a. Facility Name (If not institution, give 1744 Thistle Ct				- ,.		Location of			4c. County		201
	Funeral		5. Social Security Number 6. Se		je (In yrs. lasi	t birthday)	If Under	1 Year	if Under	24 Hrs.	8. Date of Birth		Arun	
п	Director		578-01 <b>-</b> 2751	□M 2 <b>X</b> ]F	91	Yrs.	Months	Days	Hours	Min.	Aug. 29	, 1914	<i>Çoun</i> Virc	place (State or Foreign ptry) pinia
	D .		Usual Residence of Decedent		10. 05. 7									
	shov	-	10a. State 10b. County		10c. City, T								11	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	he M	ectc	MD Anne Aru	ndel		Gar	nbril.					0.000		
	with t	Funeral Director	10e. Street and Number				10f. Zip				1	0g. Citizen of V	√hat Coun	itry?
	eath	erai	1744 Thistle Ct	12. Was Decedent	Ever in U.S.	13 \	Was Deced		1054	gin? (Spi	acify Yes or No.	USA 14 Bace	e - America	ean Indian
-	after dea or Itema	F.	1 Never Married 2 Married	Armed Forces?					, Mexicar	, Puerto	ecify Yes or No- Rican, etc.)		k, White,	
8	ursa ali, o	þ	3 ☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I□Yes 2	2XNo	Specify:			Specify	Whi	ite
21215-0036	72 hours after death with the Maryland natural; or Itema 23a or 28a-f show ileal Exantrer must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		1	(GiVA	lent's Usua kind of wor	k done d	urina mos	t of work	ina	16b. Kind of Bu	siness/Inc	dustry
2	c * @	npie	Elementary/Secondary (0-12)	College (1-4or	5+)	life. L	OO NOT us	e retired)	31 /1 / G	. 0, 110	9			
121	be filed within 72 hours after death with the Marylan it all tyginen. Id other than "natural", or Itema 23a or 28a-f show orth, Ite Medical Examinational be notified at		9 17. Father's Name (First, Middle, Last)				Cler		10 14-45-		/Fi Middle 1	Retai		.es
anc	buld be fi Mental H arked ot atic ever	Be									e (First, Middle, M		Θ)	
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 is marked other than other traumetic event, I.e.M.	은	Clayton Rowland 19a. Informant's Name/Relationship (T)	rne Print)		19b Mailin	a Address	(Street a			B. Mitche al Route Number		State Zin	Code
Ma	and 2 s salth an n 27 is ier trau		Earl L. Housenfluc			1744		stle			brills,	· ·	1054	2000)
ē,	t and the true true true true true true true tru		20a. Method of Disposition	K, DI.	20b. Plac	e of Dispo	sition (Nan	ne of	1		-	20c. Location -		wn, State
Ë	0 0 = 5		1 ⊈Burial 2 ☐ Cremation 3 ☐ F  1 4 ☐ Donation 5 ☐ Other (Specify)				ll Cer			3/27	/2006	Suitla	nd. M	MD.
Baltimore,	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service Licens	1	A		. Name an			0/	all Fune			
	707 e a		Chuan	Towel			512 N				Bowie,		0715	
	Enysician /Medical		23a. Part1. Enter the disease, or comp. shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a	0000	rarz	A	Ver	y Such as	1.	eus-e	<b>451</b> ,		Approximate Interval Between Onset and Death
	Examiner			Due to (or as	a consequen	ice of)			0					
		-e	if any leading to immediate	b. — Due to (or as	a consequen	nce of):							_	
	te be executed yslcian and e burial-transit	Examine	Cause. Enter Underlying Cause (Disease or injury that initiated events	c.										
oʻ	an an		resulting in death) Last	Due to (or as	a consequen	ice of):								
8760	ate be	licai		d.										
<u>3</u>	ertific ling p	Med	IF FEMALE:	0		7.7.								
O. Box	at the death certificate be executed by the attending phystician and tached for use as the burial-transit	Physician/Medicai	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal de	ath 3	Ectopic pri Other (sp					23d. Date Mor	e of delive	ory Day Year
rds, P	es tha	by	Part II. Other significant conditions co	ntributing to death b	out not resultin	ng in the ur	nderlying ca	ause give	n in Part I		23e. Did tob 1 ☐ Ye		-	ne cause of death? ably 4 □Unknown
Records,	The law requir ate has been s page 2 should	Completed									24a. Was as autops perform	y ned?	Were autoportor to confeath?	psy findings available inpletion of cause of
Vital	iclan: T certifical ector, p	Bec	25. Was case referred to medical examiner?						26. Place	of Death	(Check only on			
of V	dis dis	2	1 Yes 2 -10	lospital: 1   Inpatie	ent 2 ER	/Outpatien			4 🗆 NU	rsing Ho	me 5 meside	nce 6 Othe	er (Specify	1)
		on:	27. Manny of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Da	y Year) 28	Bb. Time of Injury		8c. Injury Work			28d. Describe ho	w injury occurr	bd	
sio	Attending r death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			_	М		es 2 🗌					
Division	i Big	Certification;	4 Homicide determined	28e. Place of Inj building, et	c. (Specify)	s, farm, str	eet, factory	, office			28f. Location (St. City or Town		∍r or Rurai	I Route Number,
	Hospita 4 hours Funeral	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best ner: On the basis o and manner st	f examination	dge, death and/or inv	occurred a	at the tim in my op	e, date an inion, dea	d place, th occurr	and due to the ca ed at the time, da	ause(s) and ma ate and place, a	nner as str and due to	ated. the cause(s)
207	To the within 2 To the complet	Me	29b. Signature and title of certifier	1 A	/		29c	. License	number		. 29	9d. Date signed	(Monin, I	Day, Year)
	EM		1 Nitchell	32	<u></u>		0	207	168-	fry		3/2	21/0	06
1	10)			pleted use of a	leath tem 2	a) (Type	)		Λ	4		1	1	
<u> </u>	40		2002 Vhe	rry	rout	~ W	4	V	Hu	cyli	w V	W		
	Sta Registr		MAR 2 7 2006	32. Registr	ar's Signature	E.	Y			V				

			. FOI	eartment of Health and Mental Fertificate of Death	Hygiene Reg. No. 006 11284									
2.	Physici /Medic		1. Decedent's Name (First, Middle, Last) Edwin George Hardy	2. Date of Month March	Day Year									
	Examin		4a. Facility Name (If not institution, give street and number) 7395 Sawmill Road	4b. City, Town, or Location of Death  Lusby	4c. County of Death  Calvert									
	Funeral Director		5. Social Security Number  213-09-9492  Output  6. Sex  1	If Under 1 Year   II Under 24 Hrs.   8. Date of Months   Days   Hours   Min.   Dec 2	Birth Day, Year) 3 1915  9. Birthplace (State or Foreign Country) Maryland									
re, Marylan	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or itema 23a or 28a-1 show other traumatic event, the Medical Exertine must be notified at	Funeral Director	Armed Forces?	.ocation  10f. Zip Code  20657  . Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	10d. Inside City Limits  1   Yes 2   No  10g. Citizen of What Country?  United States  14. Race - American Indian, Black, White, etc.									
		Completed by Fu	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	adent's Usual Occupation e kind of work done during most of working DO NOT use retired)  Propellant Techincian	Specify: white  16b. Kind of Business/Industry  US Government									
	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Ins M.	Be	17. Father's Name (First, Middle, Last) Charles B. Hardy	18. Mother's Name (First, Mice Nettie Hodg	ddle, Maiden Sumame)									
		ပ	19a. Informant's Name/Relationship (Type, Print) 19b. Maii	ling Address (Street and Number or Rural Route Nu Sawmill Road Lusby MD	umber, City or Town, State, Zip Code)									
			20a. Method of Disposition  1 □ Burial 2 ☑Cremation 3 □ Removal from State  4 □ Donation 5 □ Other (Specify)  20b. Place of Disposition  20b. Place of Disposition  4 □ Donation 5 □ Other (Specify)	ossition (Name of Pate ematory or other place) March 22 200 itan Funeral Service	6 Alexandria Virginia									
Balti	permit. Page Department of Important: if any injury or once.		21. Senature of Foreral Service Licensee  22. Name and Address of Facility Rausch Funeral Home  4405 Broomes Is. rd. Port Republic MD 20676											
	Physician /Medical Examiner	ı	23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	ry arrest, Approximate Interval Between										
I Records, P.O. Box 6	The law requires that the death certificate be executed attention as been signed by the attending physician and page 2 should be detached for use as the burial-transit	edical Examiner	ff any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):											
		Completed by Physician/Me		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year									
			þ	þ	þ	by	by	þ	by	þ	by	Part II. Other significant conditions contributing to death but not resulting in the CHF, Diebetcs		olid tobacco use contribute to the cause of death?  ☐ Yes ② No 3 ☐ Probably 4 ☐ Unknown
				a	vas an utopsy enformed? 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No									
Division of Vita	To the Hospital or Attending Physician: Th within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	Certification: To Be	25. Was case referred to medical examiner?  1	of 28c. Injury at Work?  M 1 Yes 2 No	Residence 6 Other (Specify) ibe how injury occurred									
Divi	oital or At	Medical Certific	4 Homicide determined 256. Place of Injury - At notine, farm, s building, etc. (Specify)	City or	on (Street and Number or Rural Route Number, Town, State)									
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer		29a. Certifier  (Check only one)  20 Medical Examiner: On the basis of examination and/or i and manner stated.											
	T wit		29b. Signature and title of certifier  KOW  MO	D 3 6 2 06	03/22/06									
1	1+1		30. Name and address of person who completed cause of death (Item 23a) (Type Kiva Meha 2403  31. Date filed (Month, Day, Year)  MAR 2 3 2006	5 Three Noteh Re	on boowyllot &									
, who shall	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2 3 2006	Sperke	20636									

		•	for State Registrar	State of Ma	ryland / D	epartme Certifica	nt of H	lealth a	and M		iene	06	11286
	Dhysiai	20	1. Decedent's Name (First, Middle							2. Date of Deat Month	h Day	Year	3. Time of Death
	Physici /Medic		ROBERT	В.		JONES				MARCH	21	2006	7:00 A M
	Examin	er	4a. Facility Name (If not institution, CLINTON NURS	•		4b. City		Location o	of Death			unty of Death	
	F				(In yrs. last birt	hday) If Und	CLINTON  If Under 1 Year   If Under 24 Hrs.			8. Date of Birth	1		EORGE 'S
	Funeral Director		579-72-0546 Usual Residence of Decedent	1⊠M 2□F		rs. Months	Days	Hours	Min.	8. Date of Birth (Month, Day, JUNE 3	1955	Cou	SHINGTON, DC
	iand ow	To Be Completed by Funeral Director	10a. State 10b. County		10c. City, Town	or Location						T	10d. Inside City Limits
	Many Many		MD PRINC	E GEORGE'S	TEMP	LE HILL							1. Yes 2 □ No
	vith the		10e. Street and Number	ATTENTITE		1	ip Code 20748			1	0g. Citizen U . S	of What Cou	intry?
	eath ve 23s		4324 SHELDON	12. Was Decedent E	ver in U.S.				gin? (Spe	ecify Yes or No-		Race - Amer	ican Indian.
imore, Maryland 21215-0036	urs after d		1 Never Married 2 Married 3 Widowed 4 ⊠Divorced	Armed Forces?	ARMY	If Yes, sp	ecify Cuba	Specify:	, Puerto	Rican, etc.)		Black, White	
	72 ho		15. Decedent' (Specify only highes	s Education		Decedent's Us (Give kind of w	al Occup	ation	t of worki	ina	16b. Kind	of Business/Ir	ndustry
	within ne.		Elementary/Secondary (0-12)	College (1-4or 5	+)	DRAFT	use retired				GOVER	NMENT	
	filed v Hygie other t		17. Father's Name (First, Middle, L	2+ ast)		DKAFI	STIMIN	18. Mothe	r's Name	(First, Middle, M			
	uld be Vental rrked c		ALEXANDER JOI	NES				ARET	THA	JONES			
	nd 2 sho lith and l 27 is me r traum		19a. Informant's Name/Relationsh DARLENE JONES	ip <i>(Type, Print)</i> -KEMP/SISTER		Mailing Address 324 SHE	s <i>(Street a</i> LDON	and Numbe AVENU	or or Rura JE TI	al Route Number EMPLE HI	City or To	wn, State, Zi MARYLA	ip Code) AND 20748
	of Head of Hea		20a. Method of Disposition 1 XBurial 2 Cremation	2 Demous from State		Disposition (Na y, crematory or		(e)		Date	20c. Locati	on - City or T	own, State
	Pag Iment tant: I		4 ☐ Donation 5 ☐ Other (Sp	ecify)	MARYLA	AND VET							MARYLAND
Ball	Departimon impor eny in		21. Signature of Funeral Service L	icersee	U	22. Name a				B. JENI LANDOVE			20785
BOX 68 death certifica e attending produce as ti	/Medical Examiner	Examiner	23a. Part1. Enter the disease, of shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Simuentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ACQUIR  Due to (or as a b.  Due to (or as a c.	e.  ED IMMUI a consequence of a consequence of a consequence of	NODEFIC of):							Interval Batween Onset and Death
	Physician/Medical	IF FEMALE: 23b: Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d. 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic 5 □ Other (s		,			23d	Date of delive	very Day Year	
	w requires tha been signed should be de	ρ	Part II. Other significant condition END STAGE RI		it not resulting in	the underlying	cause give	en in Part I.					the cause of death?
Division of Vital Records, P.O. Box 68760, Bullimore, Baltimore,	The law re- sate has bee page 2 sho	Completed								24a. Was a autops perform	ned?	4b. Were aut prior to co death?	opsy findings available ompletion of cause of 2K No
/ita	lcien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?		75.7				of Death	(Check only on	θ)		
<del>_</del>	Physion this control	은	1 Yes 2 No										ify)
lon	Jing After fune	atlon	1 ⊠ Natural 5 ☐ Pending 2 ☐ Accident investig		njury M	Work?			28d. Describe how injury occurred				
Divis	l or Atter after dea Director	Medical Certification:	3 Suicide 6 Could n 4 Homicide determi	286. Place of inju	28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	To the Hospital or Attent within 24 hours after death To the Funeral Director; completely filled in by the		29a. Certifier (Check only one)  1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and place and manner stated.									d manner as	stated. to the cause(s)
)	To the within 2 To the complet		29b. Signature and title of certifier			2:	D52	e number 9900		2		gned (Month CH 24,	
P	(4)		30. Name and address of person of Musa Momoh I				uite	301 I	Lando	over, Ma	rylan	d 207	'85
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 8 20	2. Registra	ar's Signature								

Dhysisian				Cei	tificate	e of L	eatn			g. No.	0	1287
Physician /Medical	1. Decedent's Name (Firs	NT	LEE	J.	AMES				Date of Deatl Month MARCH	Day 23 20	Year 06	3. Time of Death 5:46A
Examiner	4a. Facility Name (If not in LAUREL RE	HOSPITAL	LAUREL						E GE	ORGE'S		
Funeral Director	5. Social Security Number 579–86–8098  Usual Residence of Dece	坦	M 2DE	e (In yrs. last birthday) 4 Yrs.	If Under Months	Days	If Under 24 H Hours Mi	n. O	Date of Birth (Month, Oay, CT • 20	1961	Cou	place (State or Fore htry) INGTON, DO
28a-f show nutified at rector		County RINCE G	EORGE'S	10c. City, Town or Lo	cation				_			10d. Inside City Lin 11∏ Yes 2 ☐
23a or 28 ust be no rai Dire	10e. Street and Number 1110 DANBER	RY DRIV	RIVE			10f. Zip Code 20721				U.S.A	S · A ·	
Items In	11. Marital Status 1 ☐ Never Married 2 3 ☐ Widowed 4 🙀 🖸	Marned	2. Was Decedent I Armed Forces? 1 ☐ Yes 220 N If Yes, Give Year or Dates:	10	Was Deceded Yes, spec		spanic Origin? , Mexican, Pue Specify:	(Specifi erto Ric	y Yes or No- an, etc.)		k, White,	ean Indian, etc. ACK
the Medical Exam	15. C (Specify on:	ecedent's Educ y highest grade (0-12)	completed) College (1-4or 5	+)			tion uring most of w	orking		16b. Kind of Bu	isiness/In	dustry
and Mental Hygiene. Is marked other then aumatic event, tre Mental to Be Comp	17. Fathers Name (First,	Links of	4	L(	OAN OF		18. Mother's N			PRIVA Maiden Surnam		
ls marke raumatic	ROBERT LEE  19a. Informant's Name/R	elationship (Typ			•			Rural R		City or Town,		
Department of Health a Important: If item 27 is eny injury or other tra	ROBERT LEE  20a. Method of Dispositio  1  Burial 2  Cre 4  Donation 5	n mation 3 Re		20b. Place of Dispo cemetery, crer	sition (Nam natory or ot	ne of ther place		Date	9 2	ON, DC 20c. Location - CLINTON	City or To	
Departm Importation eny injui	21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERA 7474 LANDOVER ROAD LANDOVER, MARYLANI								VERAI			
nysician	23a. Part1. Enter the dis- shock, or heart failu Immediate Cause (Final disease or condition resulting in death)	ease, or complice re. List only one		the death. Do not ent ne. NSTEM STRO		of dying	, such as cardi	ac or re	espiratory arre	est,		Approximate Interval Betweer Onset and Deatl
Medical xaminer		s, b.	b. HYPERTENSION  Due to (or as a consequence of):  Due to (or as a consequence of):									
ician and burial-transit	Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	c. Diabetes Mellitus  Due to (or as a consequence of):									
ysicia ne bu		d.	ARTE	CRIOSCLEROT	IC CA	RDIO	VASCULA	AR D	ISEASE			
cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Completed by Physician/Medical Examir	IF FEMALE: 23b. Was decedent pregint the past 12 month 1 Yes 2 No 9 Unknown	iani	Bc. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death 3	Ectopic pre Other (spe					23d. Dat Mo		ery Day Year
s been signed be setal should be detailed by PI	Part II. Other significant	conditions con	tributing to death be	ut not resulting in the u	nderlying ca	ause give	n in Part I.			acco use contr		ne cause of death
certificate has bee irector, page 2 sho be Complete									24a. Was ar autopsy perform 1 Yes 2	y ned?	Vere auto prior to co leath?	psy findings avail mpletion of cause 20 No
s certification director	25. Was case referred to examiner?  1 ☐ Yes 2 ☐ No  27. Manner of Death	He	26. Place of Death (Check only one)  Hospital: 1 \( \tilde{\tilde									
within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification; T	2 Accident	Pending investigation Could not be determined	M 1 Yes 2 No						er or Rur	al Route Number,		
within 24 hours a To the Funeral I completely filled	29a. Certifier (Check only  29a Certifier (Check only  20a Certifier (Check											tated the cause(s)
To the comple	29b. Signature and title o	29b. Signature and title of certifier  29c. License number  29d. Date signed (Mo  3 23							(Month,	Day, Year)		
10)	30. Name and address of BRUCE NECKE					40 LA	UREL, M	ARYI	LAND 2	20707		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **JOYCE Physician** MARY JANE March 27, 2006 1:25 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Rockville Montgomery Casey House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

July 3, 1937 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours Maryland Months 1 ☐ M 2 🗓 F 68 215-34-5158 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10b. County 10a State 1 ☐ Yes 2 No Md. Derwood Montgomery Directo 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number United States 20855 16900 Glenn Oak Run Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2 XNo fYes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Ś 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Government Maintenance Supervisor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ryan Ernest C. Barger ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 16900 Glenn Oak Run Derwood, Md. 20855 John C. Joyce Sr. (Husband)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Ft. Lincoln Cem.

Date

10 East Deer Park Dr. Gaithersburg, Md. 20877

March 30,

2006

22. Name and Address of Facility DeVol Funeral Home

20c. Location - City or Town, State

Approximate Interval Between Onset and Death

Brentwood, Md.

Month

29d. Date signed (Month, Day, Year)

March 27, 2006

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

Year

Hospice

permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked other eny hipry or other treumatic event 9DES.

d

20a. Method of Disposition

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service License

wites

1 XBurial 2 ☐ Cremation 3 ☐ Removal from State

Physician /Medical Examiner

and

**Funeral** 

Director

il Hygiene. other then "natural", or items 23s or 28e-1 ehow vent, the Medical Examiner must be notified at

death

filed within 72 hours after

Baltimore, Maryland 21215-0036

Immediate Cause (Final disease or condition resulting in death) Viral Hepatitis Due to (or as a consequence of): Hepatic Encephalopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dus to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4∏Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? Yes 2 \(\overline{\Omega}\) No 1□ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 ☐ Yes 2 💢 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27 Manner of Death Medical Certification: 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide XCurtifying Physician: To the best of my knowledge, death conumed at the time, date and plane, and due to the cause(s) and manner as stated 35a: Cartifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

To the Hospitel or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Box 68760, ٥ be detached Records, P.O. the peed page 2 Division of Vital director, his After this funeral of death. within 24 hours efter death To the Funeral Director: completely filled in by the

10

Dr. Joseph Kaplan M.D. 31. Date filed (Month, Day, Year) State MAR 2 8 2006 Registrar

29b. Signature and title of certifier



30. Name and address of person while impleted cause of death (Item 23a) (Type, Print)



29c. License number

6001 Muncaster Mill Rd. Rockville, Md. 20855

D35635

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Carl William Jeffries /Medical 4a. Facility Name (If not institution, give street, and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HLART CUMBERLAND
If Under 1 Year | If Under 24 Hrs. JACREO 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 □ F Vrs Director 215-42-4384 62 Maryland 02-Sep-1943 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If item 27 ie marked other than "naturel", or Items 23a or 28a-f ehow ury or other traumatic event, the Mudical Event at must be notified at 1 Yes 2 No Director Maryland Frostburg Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18649 Cherry Lane, S.W. Funeral 21532-12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) State Juvenile Services maintenance dept 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 William E. Jeffries Margaret Buskirk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15238 Doe Hill Court 21797 Shelly Bieligk daughter Woodbine Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1. Burial 2 ☐ Cremation 3 ☐ Removal from State Depertment of Important: If any Injury or once. 4 □ Donation 5 □ Other (Specify) 26-Mar-2006 Frostburg Maryland Frostburg Memorial Park 21. Signature of Funeral Service Licens 22. Name and Address of Facility John 7 Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, another, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lung Cim Due to (or as a consequence of): Cancer, with metastasis **Physician** 6 months /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy ed by the atter in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s hes 1 Yes 1□ Yes 2 No Be 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٩ 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA this 28b. Time of Injury Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Alter 5 Pending investigation 1 Natural s effer dec. 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) wonsochesten 100055325 March 23 2006 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nds Terrace Frostbury MD21532 WONSOCK SHIN 48 Tarn 31. Date filed (Mooth Day, Year 2006 Registrar's Signature State Registrar

a1	Willis	Ja	ckson	State of		d / De	partmer	t of H	ealth a	and M	lental Hyg	•	gible.	11290
			1 - For State Registrar				ertificat	e of l	Death			g. No.	00	11230
	Physici /Medi		1. Decedent's Name (First, Middle Donal Willis								2. Date of Deat March 2		06 <sup>Year</sup>	3. Time of Death 1158 A. M
	Examir	er	4a. Facility Name (If not institution	•					Location of	of Death			nty of Death	
			Route 15 N/B @  5. Social Security Number		Age (In yrs. Ia	ast birthd		eder:	LCK If Under	24 Hrs.	8 Date of Birth		erick	place (State or Foreign
	Funeral Director		215-54-6517 Usual Residence of Decedent	1 <b>⊠</b> M 2□F	55	Yrs	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, July 20	Year) 1950	) Wash	place (State or Foreign ntry) ington, D.C.
	Maryland	tor	10a. State 10b. County  Maryland Frede			Town o	Location Lck					-		10d. Inside City Limits 1  res 2  No
	h with the	Funeral Director	10e. Street and Number 1951 Harpers (	Court	'		10f. Zip	Code 702			1	U.S.A	of What Cou	ntry?
036	72 hours after death with the Maryland "naturet", or Items 23a or 28a-f show diest Expenimer must be notified at	þ	11. Marital Status  1 □ Never Married 2 ☑ Mar  3 □ Widowed 4 □ Divorced	If Yes Give	s?	S.	3. Was Dece If Yes, spe				ecify Yes or No- Rican, etc.)		lace - Ameri lack, White, cify: <b>wh</b>	
5-0	CI 45 UI	etec	15. Deceder (Specify only highe	nt's Education est grade completed)		16a. De	icedent's Usu ive kind of wo e. DO NOT u	al Occupa	ation during mos	t of workir	ng	16b. Kind of	Business/In	dustry
121	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		omobile					auton	notive	
and 2	be filed Ital Hyg od othe event,	To Be Co	17. Father's Name (First, Middle, Paul E. Jacks						18. Mothe	er's Name	(First, Middle, A	faiden Sum	ame)	
Maryland 21215-0036	nd 2 should be alth and Mental 27 is marked o r treumatic eve	ř	19a. Informant's Name/Relations Audrey Jackson			19b. M	ailing Address Harpe	S (Street a	ourt	or or Aura Fre	Aoute Number,	City or Tow	vn, State, Zij Land	20de) 21702
Baltimore,	T E E		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S		CO	metery, o	sposition (Na crematory or c 7et Cen	ther plac	θ)   3		1.0		n-City or To	own, State aryland
Baltir	permit. Pages Depertment of i Important: If its eny injury or o		21. Signature of Funeral Service		100		22. Name ar			St	auffer :			
5	Physician /Medical Examiner	/	23a. Part1. Enter the disease, on shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	_ aM	sed the death. h line. Lipe as a conseque	. Do not		de of dyin						Approximate Interval Between Onset and Death
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. — Dee to (or	as a consequ	enes of):								
3760,	ate be executed nysicien and he burial-transit	cai	resulting in death) Last	Due to (or	as a consequ	ence of):							T N	
.O. Box 68	that the death certificate t ed by the attending physic detached for use as the L	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Fetal of t at time of dea	death	3 □Ectopic p 5 □ Other (sp						Date of delive	ery Day Year
ds, P	8 E 0	δ	Part II. Other significant condition	ons contributing to deat	h but not resul	lting in th	e underlying o	ause give	en in Part I		23e. Did tob	12		he cause of death?
of Vital Record	The law require ete has been si page 2 should t	Completed								-	24a. Was ar autops perform	/	b. Were auto prior to co death? 1 \( \sum \text{Yes}	opsy findings available mpletion of cause of
/ita	slcian: certifice rector, p	Bec	25. Was case referred to medica examiner?							of Death	(Check only one			
₹ \	× 5	ပ္	1- Yes 2 No		atient 2 🗆 E			_	4 □ Nu		ne 5 Reside			y) (scene)
Division o	ding After fune	Certification;	27. Manner of Death  1 □ Natural 5 □ Pendir 2 □ Accident investi 3 □ Suicide 6 □ Could	gation 3-23-	Day Year)	28b. Tim Injui	tp <sup>M</sup>	28c. Injury Work	at ? res 2	No T		motor n	r veh	ich that colli
DIX	i 를 들 드	Certifi	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	nined 286. Place of	Injury - At hon , etc. (Specify)	0	street, factor	y, office			28f. Location (Str City or Town 7 +4	eet and Nur State) iR	mber or Rura	N/13 @ W27
	Hospital     24 hours     Funerel     Ietely filled	edical	29a. Certifier 1 Certifyir	ng Physician: To the be Examiner: On the basi and manner	s of examinate	vledge, d on anovo	eath occurred r investigation	at the tim , in my or	e, date an pinion, dea	d place, a th occurre	and due to the ca	use(s) and te and place	manner as s e, and due to	tated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie	or				. License			1	-	ned (Month,	

111 Penn Street, Baltimor Maryland 21201

Ki,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number O.C.M.E.

29d. Date signed (Month, Day, Year) March 24, 2006

LING LI

31. Date filed (Month, Day, Year)
MAR 2 8 2006

32 Registrar's Signature

State Registrar

DHMH 17 Rev 1/2001

State

Registrar

6130 Landover Road, Cheverly, Md. 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Revathy Murthy, M.D.

MAR 2 7 2006

31. Date filed (Month, Day, Year)

016273

23

06

		1	For State	State of Maryland		rtment of H tificate of L			ne 0 0 6	11292
			Registrar  1. Decedent's Name (First, Middle, Last,	)				2. Date of Death		3. Time of Death
	Physicia			Jones				Month March 22	Day Year 2006	15:46p <sup>M</sup>
,	/Medic		4a. Facility Name (If not institution, give			4b. City. Town, or	Location of Death	Haren 22	4c. County of Deat	
	Examin	er								
			Prince George Ho  5. Social Security Number 6. Set		birthday)	Cheve	If Under 24 Hrs.	8. Date of Birth	Prince G	
	Funeral Director		11	JM 20XF 79	Yrs.	Months Days	Hours Min.	Mar. 9,1	927 Nort	nplace (State or Foreign untry) n Carolina
ш		-	579-44-6311 Usual Residence of Decedent	1.9						
	land ow		10a. State 10b. County	10c. City, T	own or Lo	cation				10d. Inside City Limits
	Man-fsh	to	Maryland Prince G	eorge Seat	Pleas	sant				1 ZXYes 2 ☐ No
	1 the	Director	10e. Street and Number			10f. Zîp Code		100	g. Citizen of What Co	untry?
	3a o		410 70th Street			20743		Un	ited Stat	es
	ms 2	Jer?	11. Marital Status	12. Was Decedent Ever in U.S.	13. V	Vas Decedent of Hi f Yes, specify Cuba	spanic Origin? (Sp	ecify Yes or No-	14. Race - Ame Black, White	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinator must be multipled at ange.	y Funeral	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces? 1 ☐ Yes 2 No If Yes, Give		r res, specily cuba i □ Yes 2□XNo	Specify:	rican, etc.)	Specify:	
21215-0036	hour tural	Completed by	15. Decedent's Edu	Year or Dates:	16a Deced	ient's Usual Occupa	ation	16	Bb. Kind of Business/	ack Industry
햔	"nai	lete	(Specify only highest grad	le completed)	(Give	kind of work done o	turing most of work	ing		
12	withi ene. than	mc	Elementary/Secondary (0-12)	College (1-4or 5+)	Dayca	are Provi	.der		Private	
2	filled Hygid ther ant, I		12th 17. Father's Name (First, Middle, Last)					e (First, Middle, Ma		
an	otal ed o	Be c		g, Sr.			Toggo	Man Cont	44	
Maryland	d Me d Me mark matic	2	19a. Informant's Name/Relationship (7)		19b. Mailin	ng Address (Street		Mae Smi al Route Number,	City or Town, State, 2	Zip Code)
Ma	d 2 s th an 7 is		Rosavalier Harpe							
e)	1 and Heal em 2 ther	1	20a. Method of Disposition	20b. Plac	e of Dispo	sition (Name of			c. Location - City or	
altimore,	uges or o		1 XBurial 2 ☐ Cremation 3 ☐ E	Removal from State Mars		natory or other plac Veteran		28/06 C	heltenham	.Marvland
tir	t. Partmer rtant rtant		' 4 □ Donation 5 □ Other (Specify,		-					
Bal	Depar Impo any ir		21. Signature of Funeral Service Licens	1 km					Homes,P.A ille, Mar	• yland 20747
			23a. Part 1 Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death.	Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between
	الشاعية		Immediate Cause (Final	Fatal Cardiac						Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a. Pacar Gardiac  Due to (or as a consequent		yenmia				
	Examiner			Peripheral Va	scula	r Disease				
	1 5 5	e	Sequentially list conditions, cause. Enter Underlying	Due to or as a cons + ue	nce of):					
	uted 1 ansit	m Hu	cause. Enter Underlying Cause (Disease or injury that initiated events	High Blood Pro	essur	e				
	and and	Examin	resulting in death) Last	Due to (or as a conseque	nce of):					
8760,	ficate be executed physician and is the burial-transit	dicall		d Diabetes Mell:	itus					
89	ficate g phy as the	Φ 1		· ·						
Box	The law requires that the death certificate has been signed by the attending ploage 2 should be detached for use as it	N/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnance		3=			23d. Date of de	
ŏ	atte	Physician/M	in the past 12 months? 1 ☐ Yes 2X No	1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea		∃Ectopic pregnancy ∃ Other <i>(specify)</i>			Month	Day Year
O.	at the de by the stached	lskı	9 Unknown	9□ Unknown						
σ.	that led b deta		Part II. Other significant conditions co	ontributing to death but not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
ds	sign sign d be	d by						1 🗆 Yes	3 2 □ No 3 □ P	robably 4XXUnknown
Records	w requir been st should	Completed						24a. Was an	24b. Were a	utopsy findings available
3ec	e law has	mpl						autopsy perform 1 Yes 2	prior to	completion of cause of
	10 -	Ç								2 □ No
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:		oth	00	th (Check only one		***
of	Phys this al dir	7	MATES 2 NO	I Impatient 2243 E	R/Outpatier 8b. Time o	II JUOA	4   Indising th	ome 5 Resider  28d. Describe hove	nce 6 Other (Spe winiury occurred	icity)
		on	27. Manner of Death  1XXNatural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	k? Yes 2 □ No	250. 200020	,,	
Sio	Attending or death.	cat	2 Accident investigation 3 Suicide 6 Could not be				163 2 110	28f Location (Str	eet and Number or R	ural Route Number
Division	l or Attend after death Director:	Certification:	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, iaim, st	reet, factory, office		City or Town,		5747.10810.74511.507,
	urs a		XX a state of	ysicien: To the best of my know	lodgo dost	h assured at the th	ma data and alasa	and due to the sa	use(s) and manner a	s stated
	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical	29a. Certifier  (Check only one)  ALL Certifying Physics  (Check only one)	niner: On the basis of examination and manner stated.	n and/or in	ivestigation, in my	ppinion, death occu	rred at the time, da	te and place, and du	e to the cause(s)
	ompl	Me	29b. Signature and title of certifier	A = -		29c. Licens	se number	29	ld. Date signed (Mon	th, Day, Year)
	- s = 0		111 m =/	mall MG		D0029	9654	3	3-23-06	
_	Tin		30. Name and address of person who	completed cause of death (Item	23a) (Tyne					
1	(10)		JeWendell McCon				e Unner M	arlhoro.	Md 20774	
	CI	ate	31. Date filed (Month, Day, Year)	Registrar's Signate	or cal		c opper n	GI IDOI O	20114	
	Regist		MAR 2 7 200	. Registrar's Signate	470					

			State of Maryl	*	artment of H			9000	11202
	- 80		Registrar Registrar	Cei	rtificate of L	Jeath	Reg 2. Date of Death	NoU U D	3. Time of Death
П	Physicia		1. Decedent's Name (First, Middle, Last)	_			Month	Day Year	
	/Medic	al	Helen Odessa 4a. Fecility Name (If not institution, give street and number)	Jone		Location of Death	March 2	4c. County of Deat	3:32 P M
	Examin	er						Calver	
			Calvert County Nursing Centers S. Social Security Number 6. Sex 7. Age (In	er yrs. last birthday)	If Under 1 Year		8 Date of Birth	9 Birt	hplace (State or Foreign untry)
	Funeral Director		578-16-8500 1 M 2X F 84	Yrs.	Months Days	Hours Min.	(Month, Day, Y Aug. 20,	1921 Wa	sh., D.C.
	D		Usual Residence of Decedent						
	how	_		c. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	88-f.	Director	MD Calvert		Owings		1.0	0	21
	with th	Dire	10e. Street and Number		10f. Zip Code	126	100	p. Citizen of What Co	ountry?
	9ath v 234	era	7111 Persimmon Lane  11. Marital Status 12. Was Decedent Ever	in II S 13 1	207 Was Decedent of Hi		ecify Yes or No-	USA 14. Race - Ame	nican Indian.
10	tter d	Funeral	Armed Forces?  1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No		Was Decedent of Hi If Yes, specify Cuba		Rican, etc.)	Black, Whit	
21215-0036	hin 72 hours efter death with the Marylend 8. ** "naturel", or items 23s or 28s-f show Medical Examiner must be notified at	by	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: wh	nite
2-0	72 ho	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa	during most of work	ina 16	b. Kind of Business	Industry
21	를 고등	nple	Elementary/Secondary (0·12) College (1-4or 5+)	life.	DO NOT use retired	1)		•	_
	77 75 75 75		10	ınsu	rance und		e (First, Middle, Ma	insuranc	e
Maryland	a d d d	Be	17. Father's Name (First, Middle, Last)	rker		Helen	Jane	Mitch	e11
Z Z	d 2 should be th end Mentel 7 is marked traumetic av	ဥ	Clarence Burkeley Pa:  19a. Informant's Name/Relationship (Type, Print)		na Address (Street a			City or Town, State, I	
<u>8</u>	カモトラ		Donald C. Jones, husband		Persimmo				
5	-14-		20a. Method of Disposition	Ob. Place of Dispo				c. Location - City or	Town, State
E O	00 0		1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		itan Crem	· 1	27-06	Alexandri	a, VA
Baltimore,	그 문원을 .		21. Signature of Funeral Service Licensee		2. Name and Addres				
ä	Depe Impo eny l		Wallan of Stor		Rausch Fu	neral Hor	ne, P.A.,	Owings,	MD 20736
	15		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arres	t,	Approximate Interval Between
	Physician		4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	nue He	ART FA	PILURE			Onset and Death
*	/Medical Examiner		Due to (or as a con	nsequence of):					
100 E	Cxammer		Sequentially list conditions, b. COROWAL	1 ANTO	RY DISC	ENSE			
	P6 ≝	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	nsequence of):					
	end end Il-tren	Examiner	that initiated events c. Due to (or as a cor	nsequence of);					
8760,	The law requires that the death certificate be executed the bas been signed by the eltending physicien end bage 2 should be deteched for use as the burlel-trensit								
687	ficete physi s the t	edic	d						
Вох	leath certifice ettending ph for use es tl	Ž	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pr		<b>3</b>			23d. Date of de	livery
m.	death e ette id for	Physician/Medical	in the past 12 months?  1 \( \text{Vas} \) \( \text{Value} \)		□Ectopic pregnancy □ Other (specify)			Month	Day Year
P.0	that the de ned by the e deteched i	hys	9 ☐ Unknown				4		
S,	es the igned be de		Part II. Other significant conditions contributing to death but no	-	inderlying cause giv	en in Part I.			the cause of death?
ord	w require been si should t	te d	PANCREATIC MASS, ANG	9/N			1 ☐ Yes	2 No 3 P	robably 4 Cinknown
of Vital Records,	lawr as be	Completed by					24a. Was an autopsy	24b. Were as	utopsy findings available completion of cause of
<u> </u>		Con					performe 1 ☐ Yes 2	ed? death? No 1 ☐ Yes	2 □ No
/ita	ysician: Th is cartificate director, peg	Be	25. Was case referred to medical examiner?		Oth		h (Check only one)	)	
of	di S	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatie		4 Nursing no	ome 5 Residen 28d. Describe how	ce 6 Other (Spe	icify)
	ding After funar	Hon	1 Natural 5 ☐ Pending (Month, Day Yea	ar) Injury	Wor	k? Yes 2 □ No	200. 000011001104	rinjury occurred	
Division	deat deat ctor: y the	fica	3 Suicide 6 Could not be 28e. Place of Injury -	At home, farm, st		0.2		et and Number or R	ural Route Number,
Β	efter efter Dire	Certification;	4 Homicide determined building, etc. (S	pecify)			City or Town,	State)	
	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: Affer th completely filled in by the funeral		29a. Certifier 1 Certifying Physician: To the best of my (Check only 2 Medical Examiner: On the basis of exa	y knowledge, deal	th occurred at the tir	ne, date and place.	and due to the cau	ise(s) and manner a	s stated.
	he H in 24 in 84 in Fe	Medical	one) and manner stated.		-				
	With To To To To To To To To To To To To To	2	29b. Signature and title of certifier	No	29c. Licens	e number	290	d. Date signed (Mont	th, Day, Year)
•			super Willety,		03	V 9 0 0		3/27	106
	5		30. Name and address of person who completed cause of death	(Item 23a) (Type	Print)	21/	Paris Fred	end MA	20678
	Sta	ato	30. Name and address of person who completed cause of death Glynis Nowy, Mo 10  31. Date filed (Month, Day, Year)  32. Registras 3  MAR 2 7 2006	Signature	Ur Juite	. 310	IT UNCE I PED.	arcicy 10	00/0
		316	MAD 9 7 200Ch A	area Ho	Brack &				

State of Maryland / Department of Health and Mental Hygiene

	FOI	rtificate of Death	Reg. N	3. Time of Death
Physician /Medical	Dessalines Jean Jacques		March 25,	2006 Year 0540 A.
Examiner	4a. Facility Name (If not institution, give street and number) 9700 Broken Land Parkway	4b. City, Town, or Location of Deat Columbia	H	c. County of Death Ioward
Funeral Director	5. Social Security Number 218 27 3755 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 1 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min.	May 26, 1	9. Birthplace (State or Foreign Country) Maryland
of filed within 72 hours after deeth with the Maryland I Hygiene. Other then "natural", or iteme 23e or 28s-1 show rent, the Medical Examiner must be notified at left. The Medical Examiner must be notified at left.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo  MD Howard Columbia	ı		10d. Inside City Limit
th with the 23e or 2	10e. Street and Number 5854 Steven Forest Road	10f. Zip Code 21045		Citizen of What Country? Inited States
urs after deeth v air, or iteme 23e Examiner must by Funeral	1 1 Never Married 2 Married 1 ☐ Yes 2 127 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2☑ No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
led within 72 hor ygiene." natura northen "natura it, the Wedical Completed	(Specify only highest grade completed) (Give life.	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	Kind of Business/Industry
s 1 and 2 should be filed within 72 hours after deeth with the Marylan if Heelth and Mental Hygiene. Item 27 is marked other then "natural", or iteme 23e or 28a-f show other treumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	17. Father's Name (First, Middle, Last) Evald Jacques		ne (First, Middle, Maide ne Leone	ducation on Sumame)
and 2 sho eelth and m 27 is m		ng Address (Street and Number or Ri Overheart Lane Co		
permit. Pages 1 a Depertment of Hee Importent: If Item eny injury or othe	20a. Method of Disposition  1	position (Name of matory or other place)  Sherd Cem. 4-1.		Location - City or Town, State  licott City, MD
permit. Depertrimporte eny inju	Jum gros algre	1112 Old Columbia	<u>Pike Ellic</u>	ke's Family FH Inc ott City, MD 21043
Physician /Medical	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	ler the mode of dying, such as cardial		Approximate Interval Between Onset and Death
rentificate be executed to ding physicien and the burial-transit of the burial-transit o	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a consequence of):			
death cer e attandir id for use ician/N		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
law requires that the as been signed by th 2 should be detache pieted by Phys	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco	o use contribute to the cause of death?
The lar			24a. Was an autopsy performed?	24b. Were autopsy findings availabed prior to completion of cause of death?
ysicien: The is certificate he director, page	25. Was case referred to medical examiner?  Hospital:	Other	ath (Check only one)	
To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.  Medical Certification: To Be (	1 Pas 2 No	f 28c. Injury at Work?  A M 1 Yes 2 No	28f. Location (Street a	7
hours aft hours aft uneral Di ly filled in	29a. Certifier 1 ☐ Certifying Physicien: To the best of my knowledge, deat	h occurred at the time, date and place	and due to the cause	s) and manner as stated.
To the Hosp within 24 hour To the Funel completely fill	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.  29b. Signature and title of certifier	29c. License number 0.C.M.E.	29d. D	the 26, 2006
)02	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) 111 Penn Stre	et, Baltimo	ore Maryland 21201
State Registrar	MAR 2 8 2006 32. Haistra's signature	front.		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No." 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) 25 2006 ar March 9:15A M **Physician Killion** Robert Lerov /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Monrovia 3914 Rosewood Road If Under 1 Year If Under 24 Hrs. Nonths Days Hours Min. (Month, Day, Year)

Oct. 22, 1941 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months 1**∏**M 2□ F California 64 Yrs. 196-30-9160 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location 10b. County 10a. State rthan "natural", or Items 23a or 28a-f ahow the Medical Exerciper must be notified at 1 Yes XXNo Directo Maryland Frederick Monrovia 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21770 USA 3914 Rosewood Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Yes 2 No 1 □ Never Married 2 Married 1 ☐ Yes 2 ▼ No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1960–62 Specify: þ White 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Transportation permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygiel Important: if itsm 27 is marked other th any injury or other traumatic avant, the 2002. Supervisor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **Killion** June E., Renwick Ray Cliva 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Opal Roberta Moore Killion/Wife 3914 Rosewood Road, Monrovia, MD 21770 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 the (Specify) Entombment Resthaven Mem. Gard 3/30/2006 Frederick, MD 22. Name and Address of Facility Stauffer Funeral Home, PA 21. Signature of Funeral Service License 1621 Opossumtown Pike, Frederick, MD 21702 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, of the art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MUOCARDIAL **Physician** /Medical Due to (of as a consequence of) Examiner metanta Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 4□Pregnant at time of death 5 Other (specify) signed by the a id be detached f 1 ☐ Yes 2 ☐ No Ö 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Cachexic 1 Yes 2 No 3 Probably 4 Unknown icate hes been si , page 2 should t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No this certificate Yes : After this certification of funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1☐Yes 2☐No 1 Inpatient 2 ER/Outpatient 3 DOA 2 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification; Attanding 1 Natural 5 Pending To the Hospital or Attanding within 24 hours efter death.
To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide LC certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D44184 MUSON Drive FREDERICK MD21702 A.Z. HEGAZ 30. Name and address of person who completed cause of death (1em 23a) (Type, Print) 31. Date filed (Month, Day, Year) MAR 2 istrar's Signature State Registrar

within 72 hours after death with the Maryland ene.  Land Director  Amadical Examination of 128-1 show and 128-1		Decedent's Name (First, Middle, Las     Daniel F. Kei     Aa. Facility Name (If not institution, give							2. Date of	Death			3. Time of Death
/Medical Examiner Funeral Director			iney						Month	D	ay Y	ear	
Funeral Director		4a. Facility Name (If not institution, give							Marc		28 20	~ ~	10:56 PM <sup>M</sup>
Director		( ) 11 0		·)				Location of De	ath	4	c. County of		_
Director	1.0	6 Annapolis Cour		ne /In vrs	last birthday)	If Under		Pines	rs. 8 Date of	Righ	Worce		
79			DM 2□F	77	Yrs.			Hours Mi		Day, Yea	7)		ace (State or Foreigr try)
arylanc arhow		Usual Residence of Decedent							1000.	. ت. او ک	20	MILC	higan
A - 120 - 1 To		10a. State 10b. County			ty, Town or Lo							10	d. Inside City Limits
cto	2	MD Worcest	er 	0	cean P	ines							1 ☐ Yes 21€ No
or 28	2	10e. Street and Number				10f. Zip	Code			10g. C	citizen of Wha	at Coun	try?
urs after death with the Mar urs after rount to notified to Funeral Director	2	6 Annapolis Co					2181				US		
ar de	2	11. Marital Status	<ol> <li>Was Deceden Armed Forces</li> </ol>	?	I.S. 13. V	Vas Deced f Yes, spec	lent of Hi rify Cuba	ispanic Origin? n, Mexican, Pue	(Specify Yes or erto Rican, etc.)	No-	14. Race - Black,		
s afte	<u> </u>	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 May Yes 2 ☐ If Yes, Give Year or Dates:		1	∏ Yes 🧏	₹ <mark>⊊</mark> No	Specify:			Specify: V	Vhit	e
tural tural	2	15. Decedent's Ed		·	16a. Deced	lent's Usua	I Occup	ation		16h	Kind of Busir	nes/Ind	usto
ed within 72 hours alt yglene. For then "natural", or it, it a Medical Examit.		(Specify only highest gra	de completed)		(Give	kind of wor OO NOT us	k done d	furing most of w	rorking	100.	Killo of Dasii	1033/1110	ustry
iene.	5	Elementary/Secondary (0-12)	College (1-4or	5+)	Direct	or Ad	lmin	istrati	ve Serv	. U.S	. Gove	ernm	ent
othe other	D	17. Father's Name (First, Middle, Last)							ame (First, Mide				
Mental Me	2	Richard Marx						Evelyn	Sybil :	Young	man		
nd 2 should be file lith and Mental Hy 27 is marked oth r traumatic event		19a. Informant's Name/Relationship (	ype, Print)		19b. Mailin	g Address	(Street a	and Number or I	Rural Route Nur	nber, City	or Town, Sta	te, Zip	Code)
and 2 salth n 27		Carolina Kenney (	wife)		6 An	napo]	is	Ct., Oc	ean Pin	s, N	d. 218	11	
of He		20a. Method of Disposition 1  1  Disposition  3 □  Oremation  3 □	Removal from State	1 4	Place of Dispos cemetery, cren	sition (Nam natory or ot	ne of ther plac	θ)	Date	20c.	Location - Cit	y or To	wn, State
Pag ment ant: I		4 □Donation 5 □ Other (Specify			lington	Nat1	L. C	em.   4-1	11-2006	Ar1	ingtor.	ı,Vi	rginia
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Dependentent of Health and Mental Hygiens.  Dependents if the 27 is marked other than "natural", or iteme 23e or 28e-1 ehow eny injury or other traumatic event, the Medical Examinating and pince.  To Be Completed by Funeral Director		21. Signature of Fueral Service Licen							The Burl Berlin	_			ome
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	olications that cause	d the deal	th. Do not ente	er the mode	e of dyin	g, such as cardi	ac or respirator	y arrest,			Approximate Interval Between
Co. Co. Co. Co. Co. Co. Co. Co. Co. Co.	al Examine	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a b. Due to (or a c. Due to (or a	s a consec	диэпсэ оП).	, γu		ens.m	A				
Physician: The law requires that the death certificate this certificate has been signed by the attending phy ral director, page 2 should be detached for use as the To Be Completed by Physician/Medic.	II yalcıdı Dıvic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant a	2 ☐ Fete at time of c	el déath 3 🗆 death 5 🗆	Ectopic pre Other (spe	ecify)		1 22 2	-	23d. Date of Month		Day Year
signer of by	2	Part II. Other significant conditions of	ontributing to death	Dut not res	sulting in the ur	nderlying ca	ause give	en in Parti.					e cause of death? ably 4 □Unknown
or Attending Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be certificated. To Be Completed by	ompiere		Professional						24a. W	itopsy informed?	dea	re autor r to con th? Yes	psy findings available apletion of cause of
clan: ertifica actor, p	U	25. Was case referred to medical examiner?						26. Place of D	eath (Check on				
hyeic his ce I dire		1 Yes 2 No	Hospital: 1 🔲 Inpat	tient 2	] ER/Outpatien	t 3 🗆 DO	A Othe	er: 4 Nursing	Home 5 R	esidence	6 Other	Specify	)
Attending Pi		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inj (Month, D	ury a <i>y Year)</i>	28b. Time of Injury	M 21	8c. Injun Work				ury occurred		
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com		3 Suicide 6 Could not be determined	286. Place of II	njury - At h etc. <i>(Speci</i>	ome, farm, stre	eet, factory	, office			n (Street a Town, Sta		or Rura	Route Number,
To the Hospital within 24 hours a To the Funsral I completely filled Completely filled Medical Ce		29a. Certifier (Check only one) 1 ☑ Certifying Ph	ysician: To the bes niner: On the basis and manners	of examina	owledge, death ation and/or inv	occurred a vestigation,	at the tin	ne, date and pla pinion, death oc	ce, and due to t curred at the tim	he cause ne, date a	(s) and manne nd place, and	er as sta	ated. the cause(s)
To the within 2 To the complet	٤	29b. Signature and title of certifier				29c	. License	e number		29d. D	ate signed (/	Month, L	Day, Year)
		) (pupe	- P-	>		1	15	1718	_	3	1/29/	00	
	-	30. Name and address of person who	completed cause of	death (Ite	m 23a) (Type,	Print)					1011		
	Į.												
T. 6+1		Joseph McShea, 31. Date filed (Month, Day, Year)		)514 trar's Sign		ck Ro	1.,	Berlin,	Md. 218	311			

			1 - For State Ragistrar	State of Ma	ryland / Depa <i>Cer</i>	artment of H		Mental Hygie	ZUUD	11297
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month March 24	Day 2006 Year	3. Time of Death 11:39 A M
	/Medic		Reuben Lantz K  4a. Facility Name (If not institution, give st	ng reet and number)		4b. City, Town, or	Location of Death		4c. County of Death	
	LAGIIII		503 Garner Avenue				dorf		Charle	
	uneral irector		5. Social Security Number 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	M 2□F	(In yrs. last birthday) 71 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	'ear) Cou	place (State or Foreign ntry) 15vlvania
P			Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation		11.091 20,		10d. Inside City Limits
Maryla	fahor	ŗ	Maryland Charles		Waldo					1 ☐ Yes 🗶 ☐ No
th the	e noti	Olrec	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cou	ntry?
aath w	a 23a	rai	503 Garner Avenue	2. Was Decedent E	ver in U.S. 13 V	2060:		necify Yes or No-	US 14. Race - Ameri	can Indian
U Z I Z I 3-UU30 filed within 72 hours after death with the Maryland	or Item Dictory	by Funeral Director	11. Marital Status 1 Never Married 2 Married	Armed Forces? 1 ∑Yes 2 □ No	9	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puerti	o Rican, etc.)	Black, White	, etc.
nours a	ural, o		3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:				16	Specify: W	nite
1 27 nin	n nat	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	king	D. KING OF BUSINESSAN	ladistry
M Mili	t the	Com	12	- College (1-401 54		ick Maso			Masonry	
albe (ii	N of Health and Menhair rygene.  If Item 27 is marked other than "natural", or Itema 23a or 28a-1 ahow or other traumatic event, the Medical Examinar must be notified at	Be	17. Father's Name <i>(First, Middle, Last)</i> Christian King					ne <i>(First, Middl</i> e, <i>Ma</i> ia Lantz	uden Sumame)	
should be	sno me s mark umatic	2	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street			City or Town, State, Zi	p Code)
and 2	m 27 li m 27 li her tra		Michael R. King -	Son	1625 P		Reef Ave		as Vegas, I	Nevada89031
Pages 1	C of of		20a. Method of Disposition 1 Durial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	moval from State	Trinity M	natory or other plac		_	aldorf, MD	OWII, State
Dermit. Pages	Department of Real Important: If Item 2 any injury or other once.		21. Signature of Funeral Service License	e MO		Name and Addre			ld Washing	ton Road
0 8	fmpo any ir		Mark M Bush	aun				e POB 156	, Waldorf	, MD 20604
			23a. Part <sup>1</sup> . Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	ations that caused to cause on each line	9.					Approximate Interval Between Onset and Death
//	ysician /ledical		disease or condition resulting in death)	Due to (or as a	consequence of):	c pe	art	Distay	£	
Ex	aminer	_	Sequentially list conditions, b.	Due to for se a	consequence of):					
pein	ansit	Examine	if any, leading to initiourate cause. Enter Underlying Cause (Disease or injury that initiated events	200 10 (0) 00 0	restracquaries ory.					
ou, be executed	ian an urial-tr	Exa	resulting in death) Last	Due to (or as a	consequence of):					
certificate be e	physic s the b	dicai	d.							
ath certif	been signed by the ettending physician and shouid be delached for use as the buriat-transit	Physician/Me	23b. was decedent pregnant	sc. If yes, outcome of		Ectopic pregnancy	,		23d. Date of deliv	•
- <del>9</del>	the ett	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at t 9 Unknown		Other (specify)	<u></u>		Month	Day Year
ords, F.O	e detac	by Ph	Part II. Other significant conditions con	ributing to death bu	t not resulting in the u	ndertying cause giv	ren in Part I.	23e. Did toba	cco use contribute to	the cause of death?
ecords, law requires t	been sign							1 Tes	2 No 3 Pro	bably 4 Unknown
a ĕ	sete has be page 2 sh	Completed						24a. Was an autopsy performe	prior to c	opsy findings available ompletion of cause of
Vital no licien: The	certificete rector, pag	e Cor	25. Was case referred to medical				26 Place of De	1 ☐ Yes 25 ath (Check only one)	No 1 □ Yes	2 □ No
T V II	Ø 0	To B	examiner?	ospital: 1  Inpatier	nt 2 ER/Outpatie	nt 3 DOA Ot			ce 6 Other (Spec	ify)
ing Phy	je je		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	Wo	ryat rk? Yes 2 ⊡No	28d. Describe how	injury occurred	
UIVISION OF VITA	tor:	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home, farm, st		142 5 140	28f. Location (Stre	et and Number or Ru	ral Route Number,
0	rsafter at Dire led in b	Cert	4 Homicide	building, etc	. (Эреспу)			City or Town,	State)	
Hospital	within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Cartifying Phys (Check only one) 2 Madical Examin	ician: To the best of er: On the basis of and manner sta	examination and/or in	h occurred at the tile estigation, in my o	me, date and place opinion, death occu	e, and due to the cau urred at the time, dat	use(s) and manner as se and place, and due	stated. to the cause(s)
To the	within 3	Me	29b. Signature and title of certifier		- 1	29c. Licens			d. Date signed (Month	
			· yalua		egoori		D-50883	3	3/24/	2006
12	IK É I		30. Name and address of person who could be seen and address of person who could be seen a seen and seen address of person who could be seen a seen and seen address of person who could be seen a seen and seen address of person who could be seen a seen and seen address of person who could be seen a seen and seen address of person who could be seen a seen and seen address of person who could be seen a seen and seen address of person who could be seen a seen and seen address of person who could be seen a seen and seen address of person who could be seen a seen and seen address of person who could be seen a seen and seen address of person who could be seen as a seen and seen address of person who could be seen as a seen and seen address of person who could be seen as a seen and seen address of person who could be seen as a seen and seen address of person who could be seen as a seen and seen address of person and seen address of person and seen address of person and seen address of person and seen address of person and seen address of person address of person and seen address of person address of p	mpleted cause of de	eath (Item 23a) (Type,	Print) La Plat	ta MD	2064	6	
	St.	ate	31. Date filed (Month, Day, Year)	32. Pegistra	r's Signature	Cast.				
	Regist	rar	MAR 2 8 2	UUb Acel	w so py					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death March **Physician** Richard 23<sup>bay</sup> 2006 ar Kennett 8:30 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 422 Crane's Roost Court Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign
Country) **Funeral** 91 1 X M 2 □ F 0870371914 060 10 3135 Yrs Massachusetts Director Usuat Residence of Decedent the Maryland or 28e-f show 10a. State 10b. County 10c. City. Town or Location 10d. fnside City Limits MD Anne Arundel Annapolis 1 ☐ Yes XXXIO Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Healih and Mental Hygiene.
ant: if item 27 ie marked other than \* natural; or items 23a or : ury or other traumatic event, the Medical Examinat hear 422 Crane's Roost Court 21409 USA Funeral 12. Was Decedent Ever in U.S. Ammed Forces? 1 2 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Coftege (1-4or 5+) Claims Manager Insurance Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Horace Kennett Adelaide Bertha Tomfohrde 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1885 E Broadway, Missoula Montana 59802 Gregory Kennett (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 3/25/06 Depertment of important: if any injury or page. Metropolitan Crematory Alexandria VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ucensee 22. Name and Address of Facility
Advent Funeral and Cremation Services
Annapolis MD and Falls Church VA Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each fine. tmmediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed physicien and s the burial-transit Exam Due to (or as a consequence of): Box 68760. Physician/Medical attending pl IF FEMALE 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of detivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. ed by the a been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۾ 1 Yes 2 No 3₽Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No s certificate has b lirector, page 2 sl 1 Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: 1 ☐ fnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 1. Natural 5 Pending after death.

Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C completely filled i 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ŝ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 21438 MARCH God cause of death (Item 23a) (Type Print)
EN TH YUS DEFENSE HIGH WAY ANAPULIS MD 21401 MICHAEL LAKENM 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Blown & Aparte Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** James Matthew King 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner RFOI SELAIR HEALTHAND REMABILITATION CENTER If Under 24 Hrs. 8. Date of Birth Month. Pay Year) 1/28/1917 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. Tennessee 11X1M 2□ F 89 Yrs. 400-09-7511 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene, and the filem 21 is marked other than "natural; or liems 23a or 28a-f ehow ury or other traumatic event; the Medical Examinant has be notified at Yes 2 No Aberdeen Harford MD Direct 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code U.S.A. 21001 89 Norman Avenue Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No Specify: Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Computer Technician 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Margaret Alice Easter Joseph M. King ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Aberdeen, Maryland 89 Norman Ave. M. Joyce King (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of IImportant: If its
any injury or of 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Aberdeen, Maryland Harford Mem. Gdns. 4/5/06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee <sup>22. Name and Address of Facility</sup>
Tarring-Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001-3399 292 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pheumoria Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical ed by the attending I detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9□ Unknown this certificate has been signed ral director, page 2 should be del Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No After this certific funeral director, 26. Place of Death | Check only one 25. Was case referred to medical Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification; 1 Natural 2 Accident 5 Pending 1 🗌 Yes 2 🗌 No within 24 hours after death. To the Funeral Director; A investigation filled in by the 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 0 Lactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medica (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar

State

30. Name and address of person who comp

31. Date filed (Month, Day, Year)

Bel Air Manyland

ted cause of death (Item 23a) (Type, Print)

North

	•	1 - State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg: No. 1 - State	300
Physicia /Medic Examin	al	Kevin Maurice Krauss  Month  Day  Year  March  24, 2006  2:4  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	ne of Death
Funeral Director		$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$	
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. It hauth and Mental Hygiene. Item 27 is marked other than "natural, or Items 23e or 28e-1 show other traumatic event. Ite Medical Examiner must be multified at	by Funeral Director	10a. State 10b. County 10c. City, Town or Location 10d. Insid	de City Limit  Yes 2∏N
hours after death tural', or Items 2:	ed by Funera	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Education  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American India Black, White, etc.  14. Race - American India Black, White, etc.  15. Decedent's Education  16a. Decedent's Usual Occupation  16b. Kind of Business/Industry	an,
ifiled within 72 I Hygiene. other than "na rent, tha Medio	Be Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)  12  17. Father's Name (First, Middle, Last)  (Give kind of work done during most of working life. DO NOT use retired)  Electrician  Electrical	
and 2 should be ealth and Mental n 27 is marked c	ToB	Kenneth Maurice Krauss  19a. Informant's Name/Relationship (Type, Print)  Renee Scott/sister  Patricia Leone Williams  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  1309 Hopewell Road, Port Deposit, MD 21904	
Page nent o ant: If ury or		20a. Method of Disposition  1 Burial 2 M Cremation 3 Removal from State  4 Donation 5 Other (Specify)  21. Signatur 1 Service 1 Page 1 Page 2 Name and Address of Facility Crouch Funeral Home	
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approx Interva Onset:	
w requires that the death certificate be executed  been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to (or as a consequence of):	14014
The law requires that the death certifica te has been signed by the attending ph tage 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month Day   4   Pregnant at time of death 5   Other (specify)	Year
equires that sen signed b ould be det	by	The significant containing at the state of the significant containing at the sig	
The lay ate has page 2	Be Completed	25. Was case referred to medical 26. Place of Death Check onlone	n of cause
ding Phy After this funeral d	Certification; To E	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Variet: 4 Nursing Home 5 Aesidence 6 Other (Specify)	Alumbar
or At after of Direction by			
To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cate and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year Doo'14575)  3 2 7 2 000	ear)
6	ate	30. Name and address of person who com Neted cause of death (Item 23a) (Type, Print)  Joseph K. Weidner, 101 Colonnial Way, Rising Sun, MD 21911  31. Date filed (Month, Day, Year)  MAR 2 9 2006	

			1100	State of	Mondon	d / Dono	rtmont of L	doalth a	and Mental F	lvaiono	_09.5.0.	
			For State	State of	marylan		iriment of r tificate of		and Mental I	Reg. No.	HIII	11301
			Registrar  1. Decedent's Name (First, Middle	a 1 ast)			imouto or	Douth	2. Date of			3. Time of Death
	Physici	an	1. 5666ddin's (tamb (t #5), ##66	1		_			Month	Day		
	/Medic	al	10019	Le		>					2006 County of Death	8:20 a M
	Examin	er	4a. Facility Name (If not institution		iber)		4b. City, Town, o					
			7114 Eversfi		7 A //	for a de la facta of a const	Hy If Under 1 Year	attsv:			Prince (	George's
	Funeral		5. Social Security Number	6. Sex 1	7. Age (In yrs.	Yrs.	Months Days	Hours	Min. (Month,	Day, Year)	Cou	place (State or Foreign ntry)
	Director		579-44-7111 Usual Residence of Decedent		93			1	Feb.	5, 19	113 Gei	rmany
	and w		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Aaryl Fshc	ō	W1 D1		, _ U	yattsv:	1110					1⊠Yes 2□No
	28a-	Director	Maryland Pri	nce George	S II	yattsv.	10f. Zip Code			10a. Citi	izen of What Cou	ntry?
	with	ā		da 1 d Dandara								,
	eath	Funerai	7114 Eversf	12. Was Dece	dent Ever in U.	S. 13. V	20782 Vas Decedent of h	Hispanic Orig	gin? (Specify Yes or		U.S.A.	can Indian,
	ter d	'n	1 Never Married 2 Mar	Armed For		1	f Yes, specify Cub	an, Mexican	gin? (Specify Yes or , Puerto Rican, etc.)		Black, White,	etc.
ဗ္ဗ	Irs a	by	3 ☑ Widowed 4 ☐ Divorced	II Yes Give			I□Yes 2⊠ No	Specify:			Specify: Wi	nite
Ş	2 hou	bel		nt's Education		16a. Deced	ient's Usual Occur	ation		16b. Ki	ind of Business/Ir	
5	n o o	pie	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-	40(54)	(Give	kind of work done OO NOT use retire	during mosi d)	t of working	St	ate Depa	artment
7	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or Itams 23a or 28a-f show event, I'm Mudical Exertic er meat to multie 1 at	Completed	Elementary/Secondary (0-12)	4	401 077	Di	rector				inguage S	
D	other int.	Be C	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name (First, Mic			
<u>m</u>	lid be lenta ked ked	To B	Richard Ott	o Andreas	Muller			M.	agdalena l	Maria	Fassbino	ler
Maryland 21215-0036	should and Men a marke umatic		19a. Informant's Name/Relations			19b. Mailin	g Address (Street	and Numbe	er or Rural Route Nu	mber, City o	r Town, State, Zij	o Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, Ita Mudical Exacutive must be publicated at another.		Marshall Mull	er - Nephe	W	3134	Port Wa	y, An	napolis,	Maryla	nd 21403	3
Baltimore,	f Hei		20a. Method of Disposition	_		lace of Dispo	sition (Name of natory or other pla	ce)	Date	20c. Lo	ocation - City or T	own, State
2	Pages nent of int: If It		1 ☐ Burial 2 ☒ Cremation  4 ☐ Donation 5 ☐ Other (\$		ptate		an Cremato		03/28/200	6 A1e	exandria	, Virginia
≣	artm ortar injui		21. Signature of Funeral Service		TIC		-		Gasch's			
ä	permit. Departr Importa any inju		1 Lalit	11/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1/1	4				Avenue,			
			23a. Part 1 Enter the disease, o	r complications the	used the deat							Approximate
	Discording		shock, or heart failure. Lis Immediate Cause (Final	only one cause in a	ach line.							Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Trunto (	or as a lonseq	15						1day
	Examiner			Code to (	CINC	dence of).	TOUT	+ 7	nfect	-100		410 0
		<u>-</u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (	or as a conseq	uence d):	Milli	+	11 201	1 1		Taays
	ted	를	Cause (Disease of Injury	<								·
_	xecu n and al-tra	Examiner	that initiated events resulting in death) Last	C. Due to (	or as a conseq	uence of):						
760,	ate ba executed hysician and he burial-transit	cal										
687	ficate phy: s the			0.								
×	that the death certifical ed by the attending phi detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregpant	23c. If yes, outo							23d. Date of deliv	erv
Вох	atter for t	cial	in the past 12 months?		irth 2 □Feta ant at time of d		Ectopic pregnanc Other (specify)	У		_	Month	Day Year
P.O.	y the	ıysi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkno	own		.,,,,,					
	that ed b deta	Į P	Part II. Other significant conditi	ons contributing to de	ath but not res	ulting in the u	nderlying cause gr	ven in Part I	. 23e. I	oid tobacco u	use contribute to t	the cause of death?
sp	The law requires that the death certifica ate has been signed by the attending ph bage 2 should be detached for use as it	d by	Alzhei	mers	TYF	20	Deme	ent	(a) 1	☐Yes 2	□N6 3□Pro	bably 4 Unknown
8	v req beer shou	Completed		etes					24a. V	Vas an	24b. Were aut	posy lindings available
Re	has has ge 2 s	E	DIUD	6163					a	utopsy erformed?	death?	opsy lindings available ompletion of cause of
_ _									1 🗆 Yı		1 ☐ Yes	2 No
₹	Attending Physician: The Ir death. ector: Atter this certificate haector: Atter this certificate haector, page	Be	25. Was case referred to medica examiner?	Hospital:			Ott	hoc	of Death (Check of	1		
of	Phys this ral di	. To	1 Yes 2 No	28a. Date o	npatient 2  of Injury	28b. Time of	IL 3 DOA	4 🗆 140	ursing Home 527	lesidence ibe how injui		(Y)
E C	ding After fune	ion	1 ØNatural 5 ☐ Pendi	ng (Monti	h, Day Yeer)	Injury	Wo	rk? ]Yes 2⊟		,	,	
<u></u>	death death tor:	Ical	3 Suicide 6 □ Could		ol Injuny . At he	ome larm etc	eet, factory, office	,,,,,		on (Street an	nd Number or Rur	al Route Number,
Division of Vital Records,	i ji fe g	Certification:	4 Homicide determ	nined 200 buildir	ng, etc. (Specif	y)	eet, factory, office		City or	Town, State	9)	2.110010.1011001
_	To the Hospitel or Attending Ph within 24 hours after death.  To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifyi	ng Physician: To the	best of my kno	wiedne death	occurred at the fi	me, date an	nd place, and due to	the cause(s)	) and manner as	stated.
	24 h	edicai	(Check only 2 Medical one)	Examiner: On the ba	asis of examina	ition and/or in	vestigation, in my	opinion, dea	ath occurred at the ti	me, date and	d place, and due i	to the cause(s)
	o the o the omple	Me	29b. Signature and title of certific				29c. Licen	se number		29d. Da	te signed (Month,	Dey, Year)
	FSFÖ		1/1/				11/	100	4337	7	02/26/20	06
٨	(11)		30. Name and address of person	who completed cause	e ol death (Iten	n 23a) (Tune	Print)		1////		03/20/20	UU
4			Ruinard C-	Stefana	10/0 / D	0 32	STO Str	stin	a frate (	+ W	Vealhin	e md 21797
	Sta	te	31. Date filed (Month, Day, Year	) R. R.	egistrar's Signa	ature			/ che c			06 e Md 21797
ŢĒ.	Registi		MAR 2 9	2006	ve M	Ann	2					

Tabb Lee 06-02040 CT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1- For RegistrarAmend item	State of Mary					giene	16	113	0.2
	Physici /Medi		Decedent's Name (First, Middle, Las	1)	EE JR	L77Uo-Jn		2. Date of De Month March	Day	Year 2006	3. Time of 0	Death A <sup>M</sup>
)	Examir		4a. Fecility Name (If not institution, give 7272 Muncaster Mil. 5. Social Security Number 6. Sec.	street and number)  L1 Road  x 7. Age (In	yrs. last birthday)	4b. City, Town, of Rockvi If Under 1 Year Months Days	If Under 24 H	rs. 8. Date of Bir	th	tgomer	ace (State or	Foreign
	Director		173-64-2997  Usuel Residence of Decedent  10a. State  10b. County	XM 2□F 24	4 Yrs.		7,00.3		0,1981	Sha	aron, F	PA
	the Mary	Director	MD Montgo	mery	Gaith	ersburg		1	10g. Citizen of		¥□Yes	
9003	72 hours after deeth with the Maryland naturel', or iteme 23a or 28e-f ehow littal Examinet must be notified at	by Funeral	1029 Souther  11. Marital Status  12 Never Married 2 Married 3 Widowed 4 Divorced	n Night La 12. Was Decedent Ever Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:	r in U.S. 13.	2087	Hispanic Origin? an, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	U.S.		an Indian, etc.	
21215-0036	within ene. then	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12) 12th	cation de completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of w d)	vorking	16b. Kind of B			
Maryland	nould be filed d Mental Hygid narked other natic event, I	To Be (	17. Father's Name (First, Middle, Last)  Tab D. Lee		201 1000		Bess	ame (First, Middle)	, Maiden Sumar Seltzei	пө) <sup>-</sup>	-	
Baltimore, Mai	Pages 1 and 2 should be ment of Heelth and Ments ant: If item 27 is marked lury or other treumatice		19a. Informant's Name/Relationship (7 Bessie M. Lee−  20a. Method of Disposition 1 Suburial 2 □ Cremation 3 € 4 □ Dopation 5 □ Other (Specify	Mother Removal from State	1029 Ob. Place of Disposer Connection, cree  101effe	Southe solution (Name of matory or other plate)  Id Ceme	rn Nigh	Pural Route Numb nt Ln Ga Date /30/06	aithers 20c. Location Hermti	sburg - City or Too	MD2 wn, State	
Balt	permit. Depertm imports eny inju		21. Signature of Funeral Service Licent	Jusus	W/ 2.	46 N. W	ashingt	Snowden con St F	Rockvil	lle,		50
8760,	Cate be executed hysician and hysician and the burial-transit the buri	icai Examiner	23a. Part1. Enter the disase, or come shock, or heer failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	nsequence of):	harp fac	4				Interval Betw Onset and D	reen
P.O. Box 68	at the death certifica by the ettending ph tached for use es th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnanc	у			ate of deliver	-	ear
	signed b	þ	Part II. Other significant conditions co	ntnbuting to death but no	ot resulting in the u	nderlying cause gr	ven in Part I.	23e. Did t	obacco use con		e cause of de	
al Records,	The ete h	Completed							psy	prior to con death?	osy findings an npletion of car 2 No	vailable use of
Vital	Physicien: Th this certificete ral director, peg	) Be	25. Was case referred to medical examiner?	Hospital:	AFTERIO :	Otto		eath (Check only o				
Division of	tending leath. tor: After the fune	Certification: To	27. Manner of Death  1 Natural 2 Accident 3 Suicide 5 Pending investigation 6 Could not be	28a. Date of Injury (Month, Day Ye	1.35	f 28c. Inju Wo	- Indianing	Stibbed	how injury occur	red sub	pjact wa	ર્ડિ
Div	To the Mospital or Attenc within 24 hours efter death To the Funeral Director: completely filled in by the		4 Homicide determined  29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	28e. Place of injury building, etc. (S	sheet y knowledge, deat	h occurred at the ti	me, date and pla	Rd. Ro	Street and Number, State) +2 CKVIIIe cause(s) and midate and place,	,Md.	luncestr	mill
	o the ithin 2 o the l	Medical	one) 29b. Signature and title of certifier	and manner stated.		29c. Licens			29d. Date signe			
	4		+ famet & original	hay, mo		OC	ME		March 2			
	,			ompleted cause of death	(ttem 23a) (Type,		enn Stree	et Baltim	nore, Ma	rylan	d 2120	1
ı	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 8 2	32. Registrar's	Signature							

FAX to M.E.

385

			1 - For State Registrar	State	of Maryla		artment of F tificate of		nd Mental Hy	ygiene Reg. No.	06	1130	)3
	9.		1. Decedent's Name (First, Middle,	Last)					2. Date of D	eath Day	Year	3. Time of	Death
	Physici /Medic		Rita Ruth Lill	У					March		2006	5:00	P M
	Examin		4a. Facility Name (If not institution,	give street and nu	ımber)		4b. City, Town, o	r Location of	Death	4c. C	County of Death		
			Springhouse at				Bethesd			Mor	ntgomery	7	
	Funeral			.Sex 1□M 2DXF		rs. last birthday) Yrs.	Months Days		Hrs. 8. Date of B Min. (Month, D	irth Jay, Ye <i>ar)</i>	Cour		•
Н	Director		230-50-8284 Usual Residence of Decedent		89	115.			Aug 4	, 1916	6 Penns	y1vani	La
	/land		10a. State 10b. County		10c.	City, Town or Lo	cation				1	Od. Inside Cit	ty Limits
	Man -fsh	ţō	MD Montgo	omery	F	Bethesda						1 <b>X</b> Yes	2 🗆 No
	r 28g	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cour	ntry?	
	th wit	aD	5101 Ridgefield	Road			20816			Unite	ed State	s	
	ems ems	Funeral	11. Marital Status	12. Was Dec	edent Ever in orces?	U.S. 13.	Was Decedent of H	lispanic Originan, Mexican,	n? (Specify Yes or N Puerto Rican, etc.)		4. Race - Americ Black, White,	an Indian,	
9	or it	y.F.	↑ Never Married 2 Marrie	d 1 ⊡Yes If Yes, G	2 X No ive	- 1	1□ Yes 2¶ No	Specify:	, ,	ľ	Specify: White		
Ş	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Items 23a or 28a-f show ant, It e Madical Examination to Item redified at	ed by	3 Widowed 4 Divorced	Year or [	Dates:								
21215-0036	in 72 "na"	Completed	15. Decedent's (Specify only highest	grade completed,		(Give	lent's Usual Occup kind of work done DO NOT use retired	pation during most o d)	of working	16b. Kin	d of Business/In	dustry	
212	with liene.	E	Elementary/Secondary (0-12)	College (	(1-4or 5+)		retary	-,		Feder	ral Gove	rnmant	
פַ	fillec I Hyg other	Be C	17. Father's Name (First, Middle, La	ist)		1 000	recary	18. Mother's	s Name (First, Middle			riment	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avant, if a Marical Examination at be notified at anone.	To B	Charles A. Lill	-у				Anna	Mary Hase	elbaue	er		
au	2 sho and I is me		19a. Informant's Name/Relationship						or Rural Route Numi			,	
≥ `	and ealth T 27 rer tr		Stephen L. Blues	tone/Att				st Hwy	. #403 Bet	thesda	a, MD 20	814	
altimore,	f ital	15	20a. Method of Disposition 1 □  Burial 2 □ Cremation 3	☐Removal from		<ul> <li>Place of Dispo cemetery, crer.</li> </ul>	sition (Name of natory or other plac	сө)	Date	20c. Loc	ation - City or To	own, State	
ᆵ	tant:		`4 ☐Donation 5 ☐ Other (Spe		Gr		Cemeter		r 1 2006		nstown,		
Ba	Dermi Depa Impo any ir		21. Signature of Funeral Service Lin	censee					Joseph Ga				
			23a. Part1. Enter the disease, or conshock, or heart failure. List on	mplications that	caused the de				ve. NW Was		on, DC	Approximate	Δ.
			shock, or heart failule. List or Immediate Cause (Final		each line. anition		or the mode of dyn	19, 04011 40 00	ardiae or respiratory	arrest,		Interval Bets Onset and I	ween
	Pnysician /Medical	r i	disease or condition resulting in death)	a	(or as a cons								
	Examiner			_	nentia	equence on.							
	3 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a cons	equence of):							-
	ecuted ind transi	Examiner	that initiated events resulting in death) Last	с									
8760,	cate be executed physician and the burial-transit	E	rosaking in doain, Last	Due to	(or as a cons	equence of):							
587	phy.	edical		d	_								
ŏ	that the death certified by the attending detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou						23	3d. Date of delive	erv	
. Box	death e atte d for	icia	in the past 12 months?	4□Preg	birth 2□Fe nant at time o		Ectopic pregnancy Other (s <i>pecify)</i> _	/			Month		/ear
P.0	the by the tache	hys	9 Unknown	9□ Unkr	nown								
	es Gu	by F	Part II. Other significant condition	s contributing to o	death but not r	esulting in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco us	e contribute to the	ne cause of d	eath?
ord	w requir been si should	ted							1□	Yes 2X□	No 3∏Prob	abiy 4 🗀 U	Inknown
Records,	e taw r has be je 2 sh	Completed							24a. Wa	psy	24b. Were auto	psy findings a	available ause of
		Cou							perl 1 ☐ Yes	formed? 2 <b>X</b> No	death? 1 ☐ Yes	2 No	
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hoonital:					of Death (Check only	one)			
o	Phys this al dir	- To	1 ☐ Yes 2X No 27. Manner of Death	Hospital: 1  28a. Date	· ·	ER/Outpatien		4 🗆 Nurs	sing Home 5 Res		4.5	Assi Livi	
0	ding Ph h. After th funeral	tlon	1X Natural 5 ☐ Pending	(Moi	nth, Day Year)	Injury	Wor	yat k? Yes 2∐No		now injury	occurred	HT A T	.115
Division of Vital	Attan deat ctor: y the	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Plac	e of Injury - At	t home, farm, str	eet, factory, office			(Street and	Number or Rura	d Route Numi	ber,
á	al or saften	Certification:	4 Homicide	build	ling, etc. (Spe	ecify)	•		City or To	own, State)			
	To the Hospital or Attanding within 24 hours after death. To tha Funaral Director: After completely filled in by the funer		29a. Certifier X Certifying (Check only 2 Medical Ex	Physician: To the	e best of my k	nowledge, death	occurred at the tir	ne, date and	place, and due to the	cause(s) a	and manner as s	tated.	
	the H nin 24 tha F.	Medical	one)	and mar	ner stated.	mation and/or in			occurred at the time				
	To To COT	Σ	29b. Signature and title of certifier		)	e / )	29c. Licens	e number		29d. Date	signed (Month,	Day, Year)	
	8		Sel-AM	( CA)	WE	1	D394	456		Marc	h 27,20	06	
	-		30. Name and address of person with the Trilla McCo				,	0 01	C1 3	m 200	1.5		
	Sta	te	Dr. Lilla McCo	12				o, unev	vy cnase,	ய ∠08	010		
•	Registr		31. Date filed (Month, Day, Year) MAR 2 8	2006	aver .	inature Lou	Well						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2006 **Physician** HAURICO 11:00 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner topkins 10 HIMORE 30h/15 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**⊠** M 2□ F Yrs. **Director** 131-22-5678 74 July 3, 1931 New York Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Maryland Montgomery Gaithersburg Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20879 14 Bell Bluff Court United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 2 should be filed within 72 hours after n and Mental Hygiene. I e marked other then "naturel", or Ita 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Nuclear Engineer Engineering 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Lynch Mary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2
Depertment of Health ar
Important: If Item 27 let. Sandra T. Lynch/ Wife 14 Bell Bluff Court, Gaithersburg, Maryland 20879 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 9 4 Donation 5 Other (Specify) All Souls Cemetery 3/27/2006 Germantown, Maryland 22. Name and Address of Facility DeVol Funeral Home 21. Signifure of Funeral Service Licenses 10 East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death METASTIC Colon **Physician** /Medical Due to (or as a consequence of): Examiner W+.ORGHA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physicien end st the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 80 attending p IF FEMALE: esn 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ After this certificate has been sign funeral director, page 2 should be 1 ☐ Yes 2 ☑ No 3 Probably 4 ☐Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Hospitel or Attending 14 hours efter death. Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital within 24 hours er 1 🗹 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Veril Wordhanson MD RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 Street Baltimore Mayland WASMAWAN Levo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 28 2006 Registrar

			1 - For State Registrar	State of Maryla		artment of H			2006	11306
			Decedent's Name (First, Middle, Last)				Journ	2. Date of Death	g. No. U U U	3. Time of Death
	Physici /Medic	al			eslie	4.07.7	1		Day Year 2006	10:40 P <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, give s			4b. City, Town, or	_	eath	4c. County of Dea	
	Funeral		12816 Brandywine 5. Social Security Number 6. Sex		. last birthday)	Brandy) If Under 1 Year		Irs. 8. Date of Birth	Prince I	George's
н	Director		212-56-0230	IM 2X□F 56	* * * * * * * * * * * * * * * * * * * *	Months Days	Hours M	Sept. 27	, 1949 Mai	ountry)
	p _		Usual Residence of Decedent						y = 0 10 1101	y ruma
	aryla.	-	10a. State 10b. County		city, Town or Lo	cation				10d. Inside City Limits
	8a-f	Director	Maryland Prince Ge	eorge's	Brandy					1 ☐ Yes 2X No
	with th	ä	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
	s 23	Funeral	12816 Brandywine R			20613			U.S.A.	
	it en d	nu	11. Marital Status 1 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 🏋 No		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? n, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race - Am Black, Whi	
38	urs af	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify:	Mhite
Š	within 72 hours after death with the Maryland ane. than "netural", or items 23a or 28a-f ahow tha Marical Examinar must be notilled at	ted	15. Decedent's Educ	cation	16a. Deced	dent's Usual Occupa	ation	1	6b. Kind of Business	
2	Pin 7	pje	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	furing most of v )	working		,
2	gian i	Completed		2	Land	l_Plannin	g		CAD Tech	nician
멀	a la H	Be (	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle, M.	aiden Sumame)	
<u>yla</u>	Ment Ment arked atic	2	Franklin T. Olive				Louise	e Payton		
Maryland 21215-0036	2 sh and te m	9	19a. Informant's Name/Relationship (Typ	·				Rural Route Number,		
a)	1 and Health Im 27		Barry Lee Leslie -		12816	Brandywi sition (Name of	ne Road	d, Brandywi		
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mertal Hygiane. Department of Health and Mertal Hygiane. Important: if item 27 is marked other than "natural, or items 23a or 28a-f show any injury or other traumatic event, the Marical Examination must be notified at once.		1 ABurial 2 ☐ Cremation 3 ☐ Re	amoval from State	cemetery, cren	natory or other place			Dc. Location - City or	
Ë	it. Parturant		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Sicense			tion Ceme	4		Clinton, M	
Ba	Depa impo any i		Turk H. Sup	Jane Mol		Name and Addres untt Fune			d Washing , MD 2060	
			23e. Part1. Enter the disease, or complic shock, or heart failure. List only one	cations that caused the dea	th. Do not ent	er the mode of dying	, such as card	iac or respiratory arres	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Unla	coco	men	ama	?		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	1001		·		
П	- Adminier		Sequentially list conditions, b.	0	1 0	sea I	7			
	ed isi	ine	rany, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cop	uence of):					
	and and II-trar	Examiner	that initiated events c. resulting in death) Last	Due to (or as a conse	quence of):					
8760,	cate be executed physicien and the burial-transit				4					
	tificate ng phys as the	edicai	d.							
Вох	eath certifi ettending for use as	Ž	IF FEMALE: 23b. Was decedent pregnant	Sc. If yes, outcome of pregr					23d. Date of de	livon
m	that the death	Cla	in the past 12 months?	1 Live birth 2 Fet 4 Pregnant at time of		Ectopic pregnancy Other (specify)			Month	Day Year
o.	t the by the	hys	9 Unknown	9□ Unknown						
ر. ت	The law requires that the death certificate has been signed by the ettending loage 2 should be detached for use as	by Physician/Me	Part II. Other significant conditions cont	tributing to death but not re	sulting in the ur	nderlying cause give	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Vital Records,	w require been signature should b	P	obelety					1 ☐ Yes	2 万¥¥u 3 □ Pi	obably 4 Unknown
သွ	awre as be 2 sho	Completed						24a. Was an	24b. Were au	utopsy findings available
Ě	ysician: The lavis certificate has director, page 2	E						autopsy performe 1 ☐ Yes 22	pd? death?	completion of cause of
ita	ician: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				26. Place of D	eath Check only one	340	20110
	Attending Physician: r death. sctor: After this certific: by the funeral director.	٥	1 ☐ Yes 2 XNo		] ER/Outpatien	t 3□ DOA Othe	r: 4 ☐ Nursing	Home 5 Agsiden	ce 6 □Other (Spe	cify)
ב	ding P		27. Manner of Seath 1 Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ?	28d. Describe how	injury occurred	
Sig	death death stor: /	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				es 2□No			
É	or At aftar Direc in by	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, stre fy)	et, factory, office		28f. Location (Stre City or Town,	et and Number or Ri State)	ural Route Number,
_	Hospital or Attenc 24 hours aftar death Funeral Director: tely filled in by the i		29a Certifier 1 Certifying Physi	icina: To the heat of Section	national and		o maga apparati	201242000	040,000	- Inches
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledicai	(Check only Medical Examine one)	ician: To the best of my kn er: On the basis of examin and manner stated.	ation and/or inv	estigation, in my op	inion, death oc	curred at the time, date	and place, and due	to the cause(s)
	Within To th compl	Me	29b. Signature and title of certifier			29c. License	number	290	d. Date signed (Mont	h, Day, Year)
			Marac	- 1m		no.	225	9 7	Ear 27	2006
0	3 -/	1	30. Name and address of person who com	npleted cause of death (Ite	m 23a) (Type, I	Print) 9/1	1 1	15001	i min	Tel.
D	58		Rene Grac	c MI		120	Tan	mel	201	32
	Star Registra		31. Date filed (Month, Day, Year) MAR 2 8 201	32 egistrar's Sign	B Ap	ale				

DHMH 17 Rev 1/2001

Registrar

			ricuse	State of Ma		d / Depa					-	giene	-09.5.0	
		•	For State Registrar		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		rtificat					Reg. No.	106	11308
8	*		1. Decedent's Name (First, Middle, L	ast)							2. Date of De.	ath Day	Year	3. Time of Death
	Physicia /Medic	al	Geraldine Ruth								March	22,	2006	5:10 a M
	Examin	46, 10 - 50	4a. Facility Name (If not institution, g				,		Location o	of Death			County of Dea	
14			3718 Ingalls Av 5. Social Security Number 6.		ie (In vrs. )	last birthday)		ttsv 1 Year	ille If Under	24 Hrs.	8. Date of Birt			George's
	Funeral Director		578-20-9749	1□M 2X1F	82	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da June 19:	y, Year) 192	3 Per	ountry) nnsylvania
	70		Usual Residence of Decedent		10- 07	. ~								10d. Inside City Limits
	anylar	2	10a. State 10b. County			y, Town or Lo								1 X Yes 2 No
	the M	ecto	Maryland Prince	George's	Нуа	ttsvi	LLe 10f. Zip	Code				10a. Citiz	en of What C	Country?
	3a or	ā	3718 Ingalls Av	zenue				784				U.S.	Α.	
	death rms 2:	Funeral Director	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.			spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)			nencan Indian,
9	after or Ita	Fu.	1 Never Married 2 Married	1 ☐ Yes 2 📉			1 ☐ Yes	**	Specify:		, , , , , , , , , , , , , , , , , , , ,		Specify:	White
Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show he Madical Exarterer must be motified at	d by	3 X Widowed 4 □ Divorced  15. Decedent's	Year or Dates:		16a Daca	dent's Usu	al Occupa	ation			16h Kir	id of Busines	
15	in 72	ojete	(Specify only highest g	rade completed)	5)	(Give	kind of wo DO NOT u	rk done a	furina mos	t of worki	ng	100.11	10 01 00011100	amoust,
212	d with giene. rr than	Completed	Elementary/Secondary (0-12)	College (1-4or	<b>5</b> +)	Secr	etary					Sea	rs	
pu	al Hyg	Bec	17. Father's Name (First, Middle, La	st)							(First, Middle		Sumame)	
yla	Ment Ment arked	2	John Thomas Mi								. Math		T C1-1-	7:- 0:-1-1
Mar	12 sh h and 7 le m traum	i	19a. Informant's Name/Relationship Mary C. Seese				-				I Route Numb			
e,	1 and Healt em 2		20a. Method of Disposition	- Daughter		L333 Place of Dispo emetery, cre					ate Unital			rnia 91784 or Town, State
no	ages ant of it: If It y or o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe			emetery, cre t Linc				03/2	9/2006	Bre	ntwood	d, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Markeal Exametration and by multiple and once.		21. Signature of Funeral Service Lice			2	2. Name a	nd Addres	s of Facili	y Gas	ch's Fu	unera	1 Home	e, P.A.
ä	Depa Impo any ii		Skent Uclas	ller		4	739 B	alti	more	Ave.	, Hyatt	tsvil	1e, MI	20781
X	-		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cause by one cause on each I	d the deati ine.	h. Do not en	iter the mod	de of dyin	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
14.00	Physician		Immediate Cause (Final disease or condition	_a Metasta	tic '	Thyroi	d Can	cer						Onsor and Dodn't
	/Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):								
1		<u>-</u>	Sequentially list conditions, if any, leading to immediate	b Due to (or as	a conseq	uence of):								
	uted J ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	G										
o,	ate be executed hysician and he burial-transit		resulting in death) Last	Due to (or as	a conseq	uence of):								
3760,	ate be hysici	licai		d										
x 68	The law requires that the death certificat te has been signed by the attending phy tage 2 should be detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregna	ancy			<del></del>			,	12d Date of a	delivery
Box	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Feta	I death 3	□Ectopic p					4	23d. Date of o Month	Day Year
o.	that the de led by the a detached t	ysic	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	9☐ Unknown										
4	es that igned b	by Pi	Part II. Other significant conditions	s contributing to death t	but not res	ulting in the u	underlying	cause give	en in Part I	l.	23e. Did 1	tobacco u	se contribute	to the cause of death?
rds	w require been sig should b	ed t	Hypertension								1 🗆	Yes 2	X No 3 □	Probably 4 Unknown
Vital Records,	as bec	Completed	Diabetes Mellity	ıs, Type II	•						24a. Was	DSV	prior t	autopsy findings available to completion of cause of
H	(0 57	Con									1 Yes	ormed? 2 X No	death 1 🗌 Y	es 2 No
/ita	Physician: T this certificat ral director, p	Be	25. Was case referred to medical examiner?	Hospital:				Oth			h (Check only	_		
of	Phys this al dil	2	1 ☐ Yes 2 X No  27. Manner of Death	1 Inpati		ER/Outpatie					me 5 N Res			pecify)
	Attending I r death. ector: After by the funer	tion	1 XNatural 5 Pending 2 Accident investigat	28a. Date of Inj (Month, Date)	ay Year)	Injury	М	28c. Injun Worl	k? Yes 2 □					
Division	if or Attendi after death. I Director: A I in by the fu	Certification:	3 Suicide 6 Could no	t be 290 Place of Ir	njury - At h	ome, farm, si	treet, factor	y, office			28f. Location (			Rural Route Number,
Ó	oepital or A hours after uneral Dire ly filled in b	Cert	4   Homicide	Bullding, e	nc. (Specif	777					0.1, 0. 10			
	To the Hospital or Al within 24 hours after or To the Funeral Directompletely filled in by	edical	29a. Certifying (Check only 2 Medical Ex	Physicien: To the besi teminer: On the basis	t of my kno of examina	owledge, dea ation and/or i	ith occurred	d at the tin	ne, date ai pinion, de	nd place, ath occur	and due to the red at the time,	cause(s) , date and	and manner place, and d	as stated. fue to the cause(s)
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and manner s	tated.		29	c. Licens	e number			29d. Dat	e signed (Mo	onth, Dey, Year)
	F 3 F 8		17.	111	X	1 11 1 1		D28					h 22,	
Λ	(20)		30. Name and address of person w	no completed cause of	death (Iter	n esa) (Type		מצע	017			11al C	.11 449	2000
1	(2)		Francine A. Higg	gs-Shipman,	M.D	. 117		1tsv	ille	Driv	e, Belt	tsvi1	1e, M	20705
1		ate	31. Date filed (Month, Day, Year)		trar's Signa	atuce								
46	Regist	rar	MAR 2 9 20	JUD JUD	1	- Again								

Physicism (Accident of Development of Section Accident of Section Accident of Development of Section Accident of Development of Section Accident of Development of Section Accident of Section Accident of Section Accident of Development of Section Accident of Section Accident of Section Accident of Section Accident of Section Accident of Section Accident of Section Accident of Section Accident of Section Accident of Section Accident of Section Accident of Section Accident of Section Accident of Section				For State Pagistrar/mend#18		Maryland / De				giene Reg. No.	0.6	11309
The fine of the control of the contr	19.0	Physici	an		le, Last)				2. Date of Dea	ath Day	- /	3. Time of Death  1421P M
State   Stat			, 10	4a. Facility Name (If not institution			4b. City, Town, o	or Location of [	Death	4c. Coun	ty of Death	
The contract of the contract									Hrs   0 Date of Bid			
Date   Part   Date						V	Months Days		Min. (Month, Da	y, Year)	Cour	ntry)
Physician  Physician		iga er						1	NOV. 0,	, 1772		
Companies of personal properties of persona		nyland how		10a. State 10b. County	/	10c. City, Town o	r Location				1	_
Companies of personal properties of persona		99-1	ctor		e George's	Brentwo						
Companies of personal properties of persona		vith th	Dire								f What Cour	ntry?
Physician  Physician		9ath v	erai			nt Ever in U.S.	13. Was Decedent of I	Hispanic Origin	n? (Specify Yes or No		ace - Americ	can Indian,
Companies of personal properties of persona	<b>'</b>	riter d	F		Armed Force	s?	If Yes, specify Cub	an, Mexican,	Puèrto Rican, etc.)	В		etc.
Companies of personal properties of persona	930	al', o	þ	3 ☐ Widowed 4 ☐ Divorced	d If Yes, Give Year or Date	s:	1 L Yes 2 X No	Ѕресіту:		Spec	Wł	nite
19   19   19   19   19   19   19   19	5-0	72 hc	etec			(0	live kind of work done	during most of	of working	16b. Kind of	Business/In	dustry
19   19   19   19   19   19   19   19	121	within ne.	du	Elementary/Secondary (0-12)	College (1-4d	or 5+)			Dofongo	11 8 (	Covern	ment
Burchell Napier    19a. Informatic Name/Ballocationship (Type, Print)   19b. Malifing Address (Sheet and Number or Plans Travel Number (City or Town, State, Apr Code)   19a. Informatic Name/Ballocationship (Type, Print)   19b. Malifing Address (Sheet and Number or Plans Travel Number (City or Town, State, Apr Code)   19a. Informatic Name Number (City or Town, State, Apr Code)   19a. Informatic Name Number (City or Town, State, Apr Code)   19a. Informatic Name Number (City or Town, State, Apr Code)   19a. Informatic Name Number (City or Town, State, Apr Code)   19a. Informatic Name Number (City or Town, State, Apr Code)   19a. Informatic Name Number (City or Town, State, Apr Code)   19a. Informatic Name Number (City or Town, State, Apr Code)   19a. Informatic Name Number (City or Town, State, Apr Code)   19a. Informatic Name Number (City or Town, State, Apr Code)   19a. Informatic Name Number (City or Town, State, Apr Code)   19a. Informatic Name Number (City or Town, State, Apr Code)   19a. Informatic Name Number (City or Town, State, Apr Code)   19a. Informatic Name Number (City or Town, State, Apr Code)   19a. Informatic Name Number (City or Town, State, Apr Code)   19a. Informatic Name Number (City or Town, State, Apr Code)   19a. Informatic Name Number (City or Town, State, Apr Code)   19a. Informatic Name Number (City or Town, State, Apr Code)   19a. Informatic Number (City or Town, State, Apr Code)   19a. Informatic Number (City or Town, State, Apr Code)   19a. Informatic Number (City or Town, State, Apr Code)   19a. Informatic Number (City or Town, State, Apr Code)   19a. Informatic Number (City or Town, State, Apr Code)   19a. Informatic Number (City or Town, State, Apr Code)   19a. Informatic Number (City or Town, State, Apr Code)   19a. Informatic Number (City or Town, State, Apr Code)   19a. Informatic Number (City or Town, State, Apr Code)   19a. Informatic Number (City or Town, State, Apr Code)   19a. Informatic Number (City or Town, State, Apr Code)   19a. Informatic Number (City or Town, State, A	D 2	를 돌아 보고 다		17. Father's Name (First, Middle,		DLA	- Departm					menc
20. Mattered of Disposition 10 Repairs 2 Commentors   Removal from State 11 Removal from State 12 Removal from State 12 Removal from State 13 Removal from State 14 Removal from State 14 Removal from State 15 Removal from State 15 Removal from State 16 Removal from State 17 Removal from State 18 Removal from State 18 Removal from State 19 Removal from	au	S E D >		Burchell Namie	r			Ji11 1	<del>Fiarini</del>	Jill F	iorin	i
20. Marind of Disposition    Spring   20   Common   Removal from State	ary	shou and M s mar umat	1-			19b. N	lailing Address (Stree	and Number	or Rural Route Numb	er, City or Tow	m, State, Zip	Code)
The content of the		and 2 haith a 127 is er tra		Hector Monday	- Spouse	the state of the s		eet, Br				
Physician   Phys	ore				3 □Removal from Sta	cemetery,	crematory`or other pla					
Physician   Phys	Ĕ	Pag ment tent:	١.,	4 ☐ Donation 5 ☐ Other (	Specify)	Fort Li						
Privician (Acidical Examiner)  The second of the second of	Ball	Depart Import any In		21. Signature of Funeral Service	ance y	lasch	22. Name and Address	ess of Facility 1timore	Gasch's F e Avenue,	uneral Hyattsv	Home,	MD 20781
Physician (season or openion)  Regulated by let conditions a consequence of cause (pleases or injury or sulling in death) Last  Sequentially list conditions.  Sequentially list condition				23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that caust only one cause on each	n line.		0 . 4		rrest,		Approximate Interval Between Onset and Death
Sequentially list conditions:  Sequentially list conditions:	3			disease or condition	a Gre	im neg	ature &	septic	cemia			
Sequentially list conditions:  Sequentially list conditions:	P.			resulting in death)	Due to (or	as a consequence of	2/ 90	besta	i de la companya de l			
Company of the summer of part I. Other significant conditions contributing to death but not resulting in the underlying available part II. Types 2 Doo 3 Probably 4 Deprine 1 Types 2 Doo 3 Probably 4 Deprine 2 Door 1 Doo	h		20	Sequentially list conditions, if any, leading to immediate	b. Due to (or		ace or	Tion	9 M			
FEMALE:   23c. If yes, outcome of pregnancy   1   1   1   23c. If yes   25c. If yes		uted d ansit	min	Cause (Disease or injury	<b>1</b>							
State   Stat	o,	exectant and and rial-tra		resulting in death) Last		as a consequence of)						
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death (Month, Day Year)  28. Describe how injury occurred with the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of the cause of death (Item 23a) (Type, Print)  29c. License number (Check only one)  29c. Place of Death (Check only one)  28d. Describe how injury occurred with the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of the cause of death (Item 23a) (Type, Print)  29c. Place of Death (Check only one)  28d. Describe how injury occurred with the time, date and place, and due to the cause(s) and manner as stated.  29c. License number (Check only one)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	176	ate be nysiciá he bu	cal		d							
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death   Check only one)  28. Describe how injury occurred   Check only one)  29. Lecation (Street and Number or Rural Route Number one)  29. Lecation (Street and Number or Rural Route Number one)  29. Signature and title of check only one)  29. Signature and title of check only one)  29. Signature and title of check only one)  29. Signature and title of check only one)  29. Signature and	9	ertifica ing ph	Med	IF FEMALE:	00-14					1/ 00/		
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death (Month, Day Year)  28. Describe how injury occurred with the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of the cause of death (Item 23a) (Type, Print)  29c. License number (Check only one)  29c. Place of Death (Check only one)  28d. Describe how injury occurred with the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of the cause of death (Item 23a) (Type, Print)  29c. Place of Death (Check only one)  28d. Describe how injury occurred with the time, date and place, and due to the cause(s) and manner as stated.  29c. License number (Check only one)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	Bo	attend for us	lan/		1 Live birth	2 Fetal death		у				
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death (Month, Day Year)  28. Describe how injury occurred with the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of the cause of death (Item 23a) (Type, Print)  29c. License number (Check only one)  29c. Place of Death (Check only one)  28d. Describe how injury occurred with the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of the cause of death (Item 23a) (Type, Print)  29c. Place of Death (Check only one)  28d. Describe how injury occurred with the time, date and place, and due to the cause(s) and manner as stated.  29c. License number (Check only one)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)		he de / the c	ysic				3 Other (specify)					
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death (Month, Day Year)  28. Describe how injury occurred with the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of the cause of death (Item 23a) (Type, Print)  29c. License number (Check only one)  29c. Place of Death (Check only one)  28d. Describe how injury occurred with the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of the cause of death (Item 23a) (Type, Print)  29c. Place of Death (Check only one)  28d. Describe how injury occurred with the time, date and place, and due to the cause(s) and manner as stated.  29c. License number (Check only one)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)		that the the the the the the the the the th		Part II. Other significant condit	tions contributing to deat	h but not resulting in t	ne underlying cause g	iven in Part I.	23e. Did	tobacco use co	ontribute to t	the cause of death?
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death (Month, Day Year)  28. Describe how injury occurred with the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of the cause of death (Item 23a) (Type, Print)  29c. License number (Check only one)  29c. Place of Death (Check only one)  28d. Describe how injury occurred with the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of the cause of death (Item 23a) (Type, Print)  29c. Place of Death (Check only one)  28d. Describe how injury occurred with the time, date and place, and due to the cause(s) and manner as stated.  29c. License number (Check only one)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	rds	quires n sign	g p	Congest	ne Hear	Jones	re		1	Yes 2□No	3 ☐ Pro	bably 4 Nnknown
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death (Month, Day Year)  28. Describe how injury occurred with the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of the cause of death (Item 23a) (Type, Print)  29c. License number (Check only one)  29c. Place of Death (Check only one)  28d. Describe how injury occurred with the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of the cause of death (Item 23a) (Type, Print)  29c. Place of Death (Check only one)  28d. Describe how injury occurred with the time, date and place, and due to the cause(s) and manner as stated.  29c. License number (Check only one)  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	00	aw rec	plete	Abdomen	al wall	Cellulita	7				b. Were aut	opsy findings available
Company   Comp	Ä	The It	mo	Obstruct	in Steer	6 Alm	a,		perfe	ormed?	death?	
Company   Comp	ita	sian: artifica ctor, I	0	25. Was case referred to medic		- 4			of Death (Check only	оле)		
Company   Comp	7 \	hysic this co	P	1 ☐ Yes 2 € No	1 Minb		atient 30 DOA	4 🗆 Nul:				ify)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHALLO H. AS HAI 8100 Government Rd, Jawhan MO  State 31. Date filed (Month, Day, Year)  Registrar's Signature	ů.	ling F	lon:	Natural 5 Pend	ling (Month,					now injury occ	Julieu	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHALLO H. AS HAI 8100 Government Rd, Jawhan MO  State 31. Date filed (Month, Day, Year)  Registrar's Signature	isi	death ctor: y the	licat	3 ☐ Suicide 6 ☐ Could	d not be	Injury - At home, farn			28f. Location	(Street and Nu	mber or Rui	ral Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHALLO H. AS HAI 8100 Government Rd, Jawhan MO  State 31. Date filed (Month, Day, Year)  Registrar's Signature	ò	after after Direct	erti	4 Homicide	building	, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,		City or To	wn, State)		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHALLO H. AS HAI 8100 Government Rd, Jawhan MO  State 31. Date filed (Month, Day, Year)  Registrar's Signature		Hospite 24 hours Funeral		(Check only 2 Medica	at Examiner: On the bas	is of examination and/						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  KHALLO H. AS HAI 8100 Government Rd, Jawhan MO  State 31. Date filed (Month, Day, Year)  Registrar's Signature		Fo the vithin Fo the comple	Me		N O	1 11	29c. Licer	nse number		_	1 .	
State 31. Date filed (Month, Day, Year) . Registrar's Signature		F > F 0		* My	bhs.	K- Asho	i Do	06033	19	03/	27/0	6
State 31. Date filed (Month, Day, Year) . Registrar's Signature	1	2(3)		30. Name and address of perso	n who completed cause	of death (Item 23a) (T		Goo	d luch &	Pd, N	Lauh	au MD
Registrar MAR 2 9 2006	100				2006 Rec	gistrar's Signature	arte					

Physician   Medical Examiner	of Death
STEPHEN ANDERSON MILLER   March 21, 200	06 7:01 PM
4a. Facility Name (II not institution, give street and number)  HOLY CROSS HOSPITAL  Funeral Director  4a. Facility Name (II not institution, give street and number)  HOLY CROSS HOSPITAL  5. Social Security Number 6. Sex 1 M 2 F 5 Yrs.  Age (In yrs. last birthday) 5. Social Security Number 5. Social Security Number 5. Social Security Number 6. Sex 1 M 2 F 5 Yrs.  Hours Min.  January 22, 10  Janu	of Death
HOLY CROSS HOSPITAL  Silver Springs Montcomposition  Funeral Director 5. Social Security Number 6. Sex 1 May 2 F 52 Yrs.  Silver Springs Montcomposition of Security Number 12.4 Hrs. 8. Date of Birth 1.954 Months Days Hours Min. January 22, 10. Security Number 1.00 Situation of December 1.00	9. Birthplace (State or Foreign
Funeral Director 5. Social Security Number 6. Sex 1 Months Days Hours Min. January 22, Usual Residence of Decedent 100 Sixts 1	9. Birthplace (State or Foreign
Director    577-74-2243   1 Mary 2 F   52 Yrs.   Months Days Hours Min. January 22, 1	Country)
Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	Vachington
10c. City, Town or Location	washington,
	10d. Inside City Limits
Washington	1)X)Yes 2 □ No
Washington  10e. Street and Number  10g. Citizen of V	What Country?
1928 Kearney Street NE 20018 United	States
1928 Kearney Street NE  1928 Kearney Street NE  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?)  14. Race Blace	ce - American Indian,
1 Never Married 2 Married 1 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Specify:	ck, White, etc.
3 □ Widowed 4 □ Divorced	y: Black
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working) (Give kind of work done during most of working) (File book of the property o	usiness/Industry
Depart    Special Assistant to   Depart	ment of
Health Director Health	
18. Mother's Name (First, Middle, Last)	ne)
DC Washington  106. Street and Number 106. Street NE 107. Zip Code 109. Citizen of V 20018 United 109. Citizen of V 20018 United 11. Marital Status 12. Was Decedent Ever in U.S. Amed Forces 12. Was Decedent Ever in U.S. Amed Forces 12. Was Decedent Steet in U.S. Amed Forces 12. Was Decedent Steet in U.S. Amed Forces 12. Was Decedent Steet in U.S. Amed Forces 12. Was Decedent Steet in U.S. Amed Forces 12. Was Decedent Steet in U.S. Amed Forces 12. Was Decedent Steet in U.S. Amed Forces 12. Was Decedent Steet in U.S. Amed Forces 12. Was Decedent Steet in U.S. Amed Forces 12. Was Decedent Steet in U.S. Amed Forces 12. Was Decedent Steet In U.S. Amed Forces 12. Was Decedent Steet In U.S. Amed Forces 12. Was Decedent Steet In U.S. Amed Forces 12. Was Decedent Steet In U.S. Amed Forces 12. Was Decedent Steet In U.S. Amed Forces 12. Was Decedent Steet In U.S. Amed Forces 12. Was Decedent Steet In U.S. Amed Forces 12. Was Decedent Steet In U.S. Amed Forces 12. Was Decedent Steet In U.S. Amed Forces 12. Was Decedent Steet In U.S. Amed Forces 12. Was Decedent Steet In U.S. Amed Forces 12. Was Decedent Steet In U.S. Amed Forces 12. Was Decedent Steet In U.S. Amed Forces 12. Was Decedent Steet In U.S. Amed Forces 12. Was Decedent Steet In U.S. Amed Forces 12. Was Decedent Steet In U.S. Amed Forces 12. Was Decedent Steet In U.S. Amed Forces In U.S. Amed For	
19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Marylan	4 20004
Darion Griffin / Sister 12213 Cedar Hill Drive Silver S	Springs,
20b. Place of Disposition (Name of Date competency, compactency, compa	- City or Town, State Maryland
1 Burial 2 Mcremation 3 Removal from State Riverdale Park 4 Donation 5 Other (Specify) Crematory 2006  Riverdale Park Crematory 2006  Riverd	ale,
21. Signature of Funeral Service Licensee	1 Home 4804
Georgia Ave. NW Washington,	
23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, list only one cause on each line.	Approximate Interval Between
Rhysisian Immediate Cause (Final	Onset and Death
/Medical disease or condition resulting in death)  disease or condition resulting in death)  a. Cardiopulmonary Arrest  Due to (or as a consequence of):	
Examiner	
Cause. Enter Underlying Cause. Cause (Disease or injury that initiated events	
f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
dical Expression of the purisities of the purisities of the purisities of the purisities of the purisities of the purisi	
S the state of the	
IFFEMALE: 23d. Date   23d. D	ite of delivery
To be past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  More past 12 months?  4 Pregnant at time of death 5 Other (specify)	onth Day Year
1 Yes 2 No 9 Unknown 9 Unknown	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	tribute to the cause of death?
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Chronic Renal Failure  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.  Chronic Renal Failure  24a. Was an 24b. V	3 Probably 4 Unknown
Chronic Renal Failure  1 Yes 2X No  24a. Was an autopsy performed? 1 Yes 2X No  1 Yes 2X No	
The state of the s	Were autopsy findings available prior to completion of cause of death?
1  Yes 20 No 1	1 ☐ Yes 2 ☐ No
Use a Mark to medical 26. Place of Death (Check only one)  Hospital: Hospital: Other to medical examiner?	
1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other	
27. Manner of Death  1 Matural 5 □ Pending (Month, Day Year)  1 Matural 5 □ Pending (Month, Day Year)  28b. Time of Injury 28c. Injury at Work?  1 □ Yes 2 □ No	red
2 Garage Place of Injury At home form short house with a specific Constant Number 1	
28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 3 28c. Injury at Work?    Second Control of Contro	ber or Hural Houte Number.
A Section of the sect	anner as stated. and due to the cause(s)
29a. Certifier (Check only only only only only only only only	
29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29b. Signature and file of certifier  29c. License number	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and file of certifier  29c. License number  29c. License number  29d. Date signed	ed (Month, Day, Year)
DC14582 March 2:	ed (Month, Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  March 2:	2, 2006
DC14582 March 2:	2, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of IV	iaryland /	•	tificate of L			eg. No.	D	11311
			1. Decedent's Name (First, Midd	le, Last)					2. Date of Deat	h Day	Year	3. Time of Death
	Physici /Medio		Mary Ruth	Mascetti					Month March 2			6:00 p M
4	Examir		4a. Facility Name (If not institution	n, give street and number	)		4b. City, Town, or	Location of Death	)	4c. County	of Death	
			Genesis Eldero				Severna			Anne A		
п	Funeral		5. Social Security Number 161-26-9809	6. Sex 7. A 1 ☐ M 2 ☑ F	ge (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 25,	Year)	9. Birthp	place (State or Foreign ntry)
	Director		Usual Residence of Decedent		74	YIS.			Feb. 25,	1932	Penn	sylvania
	land DW		10a. State 10b. County		10c. City, Tov	wn or Lo	cation				1	0d. Inside City Limits
	Mary	ğ	Maryland Anne	Arundel	Crofto	n						1 ☐ Yes 2 📉 No
	r 28a	Director	10e. Street and Number		1020260		10f. Zip Code		1	0g. Citizen of	What Cour	itry?
	h with	D E	1410 Nestlewoo	d Court			21114		U	.S.A.		
	deat	Funerai	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	13. V	Vas Decedent of Hi	spanic Origin? (S		14. Rac	e - Americ	
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland aritment of Heath and Mental Plygiene. orient: If Item 27 is marked other than "neture!", or Items 23a or 28a-f ehow injury or other traumatic event, the Medical Evanimer must be rediffied at 9.	by Fu	1 ☐ Never Married 2 ☐ Mar 3 🛱 Widowed 4 ☐ Divorces	ned 1 ☐ Yes 2 🔀		-	☐ Yes 2Ĭ No		o i iloan, oto.,	Specif	ck, White. V: Whi	
Maryland 21215-0036	thou sture			nt's Education	16a	a. Deced	lent's Usual Occupa	tion		16b. Kind of B		
15	nin 72	Completed		st grade completed)		(Give	kind of work done d OO NOT use retired)	uring most of wor	kina	Verizon		,
212	d with	E	12	College (1-4or		nef	its Assis	tant		Telepho	ne C	ompany
Þ	e file al Hyg othe vant,	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's Nan	ne (First, Middle, M	Maiden Suman	ne)	
<u>la</u>	12 should be filed within h and Mental Hygiene. 7 is marked other than " traumatic evant, the Men	To	Frank Killian					Sarah Fi	nnerty			
an	2 sho and l		19a. Informant's Name/Relations			b. Mailin	g Address (Street a	nd Number or Ru	ral Route Number,	City or Town,	State, Zip	Code)
	1 and 2 Health tem 27		Sharon William	s - Daughter			Patuxent					
Baltimore,	Pages 1 nent of He nnt: If Iten vry or oth		20a. Method of Disposition 1   Burial 2 □ Cremation	3 □Removal from State			sition (Name of natory or other place			20c. Location -		
Ë	E Pa tmen tent:		`4 Donation 5 □ Other (5		Gate	of H	leaven Cer	netery 03	3/25/2006	Silver	Spri	ng, MD
Ba	permit. Pages 1 ar Department of Hea Importent: If Item eny injury or other once.		21. Signature of Funeral Service	Licensee	170137	3 22	Name and Addres					P.A. MD 20781
			23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complications that cause	d the death. Do	not ente					Í	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition			V	LLVAR	CARCI	Vous			Onset and Death MONTHS
	/Medical Examiner		resulting in death)		a consequence			- FIRE CI	0101			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	Examine	L	Sequentially list conditions,	b								
	ed .	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	d Due to (or as	a consequence	Of }:						
	xecul and	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequence	of):						
68760,	tificate be executed ng physician and as the burial-transit			L d								
.89	= O et	ledicai										
Вох	eath cert attendin		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2   Fetal deatl	h 3□	Ectopic pregnancy				te of delive	
	at the deal by the att stached fo	Physician/N	in the past 12 months? 1 ☐ Yes 2 █ No 9 ☐ Unknown		t time of death		Other (specify)	-		Mo	nth	Day Year
P.0	that the ed by detach		Part II. Other significant conditi	ons contributing to death	out not resulting	in the un	iderlying cause give	n in Part I	23e Did toh	acco use cont	ribute to th	e cause of death?
Vital Records,	as ng	ed by									3 ☐ Prob	1.0
00	aw require s been si 2 should l	piete							24a. Was ar		Were autor	psy findings available
R	The lav	Completed							autops perform	ed2	death?	npletion of cause of 2□ No
ita	icien: Th certificate rector, pag	BeC	25. Was case referred to medica examiner?					26. Place of Dea	th (Check only one	3		
of <	is di	၉	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpati		utpatien	3 □ DOA Othe	r: 4 Nursing H	ome 5 Reside	nce 6 □Oth	er (Specify	)
n c		on:	27. Manner of Death  1 Natural 5 ☐ Pendii	28a. Date of Inj (Month, Da	ury 28b. ay Year)	Time of Injury	28c. Injury Work	?	28d. Describe ho	w injury occur	ed	
Sio	Attending or death. ector: After	cat	2 Accident investi	not be	ium. Athama 6			es 2 □No	28f. Location (Str	matand Alumb	as as Dum	I Bouto Mumbo s
Division		Certification:	4 ☐ Homicide determ	building, e	tc. (Specify)	arm, stre	eet, factory, office		City or Town		ei oi muia.	noble Number,
	To the Hospital or within 24 hours affer To the Funeral Dirt completely filled in I	Medical C		ng Physicien: To the best Examiner: On the basis of and manner s	of examination as							
	To the within 2 To the complet	Me	29b. Signature and title of certifie				29c. License	number	29	d. Date signe	d (Month, i	Day, Year)
			1/2: (	SHU1-	mo		73	1136	۷,	March 2	3, 20	)06
	(10)		30. Name and address of person	who completed cause of	death (Item 23a)	(Type, I	Print)		2 ;		-,	
			BRIAN C- 0	JALLACE	my a	906	5 KIL	BRIDE	RO, B	ALIM	ole	006 nu) 21236
	Sta		31. Date filed (Month, Day, Year,	3 Regist	rar's Signature	1			· ·		(	
	Registr	ar	MAR 28	LUUD DOCA	~ ~ ~	4/1						

		1	For State Registrar	State	of Maryla		artment of H		d Mental Hy	giene Reg(No.U U 6	11312
	Physicia		Decedent's Name (First, Midd     Dante	le, Last)		Marin	ari		2. Date of Dea Month March 23,	Day Ye	3. Time of Death 4:31 A M
	/Medic Examin		4a. Facility Name (If not institution	n, give street and	number)		4b. City, Town, or	r Location of De		4c. County of D	Death
	Examili	E1	Southern Maryland				Clint	con		Prince Ge	eorge's
186	Funeral Director		5. Social Security Number  579–32–2274	6. Sex 1XXM 2□ I		rs. last birthday, Yrs.	Months Days		lin. 8. Date of Birt (Month, Da October	y, <sup>Year)</sup> 9. 10, 1926 W	Birthplace (State or Foreign Country) Vashington, DC
	P .	-	Usual Residence of Decedent		100	City, Town or L	ecation				10d. fnside City Limits
	uryiar show	. 1	10a. State 10b. County	/		shington,					1XXYes 2 □ No
	Ba-f	cto	DC		Wa	Simigron				10g. Citizen of Wha	A Country?
	th with th	ai Director	10e. Street and Number 2431 33rd Street	et S.E.				0020		USA	
920	be filed within 72 hours after death with the Maryland rial Hygiene.  and Hygiene.  ed other than "naturel", or items 23a or 28a-f show event, in Medical Examinal must to Lydified.	by Fur	11. Marital Status  1 Never Married 2 MMa 3 Widowed 4 Divorce	rried Armed	Decedent Ever in If Forces? es 2  No Give or Dates:	W II 13.	Was Decedent of H If Yes, specify Cuba 1 Yes	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No uerto Rican, etc.)	Black, V	American findian, White, etc. White
Maryland 21215-0036	nin 72 ho  in "natur Medical	Completed	15. Decede (Specify only high Elementary/Secondary (0-12)		e <i>d)</i> ge (1-4or 5+)	(Givi	edent's Usual Occup e kind of work done DO NOT use retired	during most of	working	16b. Kind of Busin	
212	d with	E O	12			Maste	er Plumber			Self-Emp.	loyed
land	ould be filed Mental Hygi arked other attc event.	To Be C	17. Father's Name (First, Middle Genesio A.	, <sub>Last)</sub> Marinari	Ĺ			18. Mother's Mar	Name (First, Middle, y Cichola		
Mary	and and le m	-	19a. Informant's Name/Relation Rose M. Marinari						Washington	er, City or Town, Sta	
d)	s 1 and 2 if Health item 27 other tra		20a. Method of Disposition		20	b. Place of Disp	osition (Name of ematory or other pla	ca)	Date	20c. Location - Cit	y or Town, State
9	ages ent of nt: If i		1 ⊠Burial 2 ☐ Cremation 4 ☐ Donation 🔑 ☐ Other (		om State		t Cemetery		/25/2006	Washington	n, DC
Baltimore,	permit. Pages Department of I Importent: If its any injury or of		21. Signature meral Service	also /					George P. Ka Oxon Hill,	las Funeral Marvland	Hame PA 20745
			23a. Part Enter the disease, shock, or heart failure. List	or complications that only one cause	on each line.	leath. Do not er	nter the mode of dyi	ng, such as car			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue	SEVERE I		RICULAR DYS	FUNCTION			
	Examiner	_	Sequentially list conditions,	b	PREVIOUS to (or as a con		IAL INFARCT	ION			
	pet nsit	nine	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	<		Y ARTERY	DTSFASE				
,092	te be executed ysicien and te burial-transit	cal Examiner	that initiated events resulting in death) Last	Q.	a to (or as a con						
687	icate phys s the			d							
Box	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ L 4 ☐ P	, outcome of pre ive birth 2 □ I regnant at time Inknown	Fetal death 3	☐Ectopic pregnanc ☐ Other (specify)	ey .		23d. Date o Month	
ds, P.O.	uires that the signed by Id be detacted	d by Ph	Part II. Other significant condi HYPERTENSION,	tions contributing DIABETES,	to death but not CORONARY	t resulting in the ARTERY B	underlying cause gr YPASS GRAFT	ven in Part I.	_		ute to the cause of death?
Records,	ne law requir s has been si ge 2 should	Completed by	SURGERY TWICE						24a. Was	psy prid ormed? dea	ore autopsy findings available or to completion of cause of ath?  Yes 2 \sum No
		ပိ	25. Was case referred to media	ral				26 Place of	1 ☐ Yes  Death (Check only		
₹	Phyelcien: The la rthis certificate has ral director, page 2	00	examiner?	Hospital:	1 🖔 Inpatient	2 ☐ ER/Outpati	ent 3 DOA Ot	han		idence 6 □Other	(Specify)
on of	ending Phye eath. or: After this the funeral di	tion: To	27. Manner of Death 1 XNatural 5 ☐ Pend	28a. [	Date of Injury Month, Day Yea		of 28c. Inju	ıryat ork? ]Yes 2 ☐ No		how injury occurred	
Division of Vital	or Atten after deat Director: in by the	ertifica	3 Suicide 6 Cou	d not be 28e. F	Place of Injury -	At home, farm, soecily)	street, factory, office	-	28f. Location City or To	(Street and Number own, State)	or Rural Route Number,
	To the Hospitel or Attending Phyminin 24 hours after death. To the Funerel Director: After this completely filled in by the funeral	edicai Certification:	29a. Certifier XXX-ertific (Check only one)	al Examiner: On t	o the best of my	/ knowledge, de mination and/or	ath occurred at the tinvestigation, in my	ime, date and p opinion, death	place, and due to the occurred at the time	cause(s) and manr , date and place, an	ner as stated. d due to the cause(s)
	thin 2 the mple	Med	29b. Signature and title of certi		mainer stateu.		29c. Licen	ise number		29d. Date signed (	Month, Dey, Year)
	To To Con		13/11	In.	MD		D	28035		March 23,	2006
	(12)		30. Name and address of person	on who completed	cause of death	(ftem 23a) (Typ	e, Print)				
1	(7		Basirmohmad F			<u>Piscatawa</u>		310 Clint	ton, Marylar	nd 20735	
· Sign	St Regist	ate	31. Date filed (Month, Day, Ye	ar)	2. Registrar's S	Signature -					

		•	1 - State Amend Item	State of Ma 23a per I	aryland Dr.,G	1 / Depa 855 <b>_0</b>	rtmen tiricati	tot H 26gh	ealth a Death	and M	lental Hy	giene Reg. No.	006	1313
	E au Eine		1. Decedent's Name (First, Middle, La	st)							2. Date of De	ath Day	Year	3. Time of Death
	Physicia /Medic		WILLIAM	RILEU				M.	ALON	EJR.	MARCI	H 25		00:45 AM
	Examin	-	4a. Facility Name (If not institution, give	e street and aumber)			4b. City,	Town, or	Location of	of Death		4c. 0	County of Dea	th
			THE JOHNS HOPKIN	13 HOSPITA	1L		BAL	TIMO	RE C	ITY				
	Funeral		Social Security Number     6. S	ex 7. Age	e (In yrs. Ia 78	ast birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	av Year)	_   C	thplace (State or Foreign ountry)
	Director		532-20-5893	AGA	70	Yrs.					Aug. 2	8 <b>,</b> 19	27 Was	hington
	and wo		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					_		10d. Inside City Limits
	dehc	ō	VA Arling	ton	Ar	lingto	n							1 ZYes 2 □ No
	the 28a	Director	10e. Street and Number				10f. Zip	Code				10g. Citiz	en of What C	ountry?
	3a or	ā	1530 Key Blvd. #3	310				222	00			Unit	ed Sta	tes
	me 2	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?			Vas Dece	dent of Hi	spanic Ori	gin? (Spe	ecify Yes or No		4. Race - Am	erican Indian,
9	or ite	Fu	1 ☐ Never Married 2 📉 Married	1 TYes 2 1	No 9-4.	)	Yes		Specify:	i, rueito	Rican, etc.)	1.	Black, Whi Spec <i>ity:</i> Wh	
21215-0036	n 72 hours after deeth with the Maryland "natural", or Iteme 23a or 28a-f ehow adical Examinat must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:	6-7	2		2.00	Opociiy.				Specily. WII	Tre
, L	72 h netu	Completed	15. Decedent's Ed (Specify only highest gra			16a. Deced	kind of wo	rk done d	during mos	t of worki	ng	16b. Kin	d of Business	/Industry
12	within lene. then	ш	Elementary/Secondary (0-12)	College (1-4or 5	i+)	Lt. Co	00 NOT us		•			IIC :	Malaa	
22		e Co	17. Father's Name (First, Middle, Last)	+5		<b>DC.</b> OC	71. 0	J AI			(First, Middle	-	Milita Sumame)	ry
an	d be	00	William Riley Mal											
Maryland	2 should and Men is marke aumatic	၉	19a. Informant's Name/Relationship (			19b. Mailir	g Address	(Street a	V 1 V 1 and Number	an H er or Rura	ellen S	er, City or	S Town, State,	Zip Code)
	V 40 = 4		Alison Dodge Malo	ne / Wife		1530	Kev 1	B1vd.	. #31	9 Ar	lingtor	. VA	22200	
Baltimore,	s 1 and 3 if Health item 27 other tr		20a. Method of Disposition		20b. Pl	ace of Dispo metery, cren	sition (Nar	ne of		0	Date	20c. Loc	ation - City or	Town, State
Ę	permit. Pages 1 Depertment of H Important: If Ite any injury or ot		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐		Nat	ional	Crema	atory		3-28	-06	Falls	s Chur	ch, VA
alti	Departir Departir Importe any Inju		21. Signature of Funeral Service Licer	isee							eph Gaw	ler's	s Sons	Inc.
0	88 1 8		John Rupel	A JEZKUL		51	30 W	Lscor	nsin .	Ave.	NW Was	shing	ton DC	20016
-	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each lir a. DEDOMP	ENSA	Corona (TED H	rv A	rtery	v Dis		or respiratory a	rrest,		Approximate Interval Between Oz et and Death
	Examiner			ASYSTOL	Part of	erice or,							_	AMMITTER
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as		ence of):								O MINUTES
	cuted nd ransif	Examine	that inflated events	c										
, 00	death certificate be executed e ettending physicien and id for use as the burial-transit	Ex	resulting in death) Last	Due to (or as	a consequ	ence of):								
8760,	cate b	Physician/Medical	•	d		·		-						
9 X	eath certific ettending p	/Me	IF FEMALE:	23c. If yes, outcome	of pregnar	ncv						20	3d. Date of de	di car
Вох	eath etten I for u	clan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3□	Ectopic pr					2.	Month Month	Day Year
o.	the che	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown										
<u>α</u>	igned by	by Pt	Part II. Other significant conditions of	contributing to death b	ut not resu	lting in the ur	nderlying c	ause give	en in Part I		23e. Did 1	tobacco us	e contribute t	o the cause of death?
of Vital Records,	law requires as been sign 2 should be	d b									10	Yes 2   ✓	)No 3□P	robably 4 Unknown
000	law requir as been s 2 should	plet									24a. Was		24b. Were a	utopsy findings available
æ	Pe h	Completed									auto perfo	ormed? 2 🗱 No	death?	completion of cause of s 2 No
ita	certifical rector, p	BeC	25. Was case referred to medical examiner?						26. Place	of Death	(Check only	•		
<b>&gt;</b>	\$ w 5	<b>To E</b>	1 ☐ Yes 2 💢 No	Hospital: 1 Inpatie		ER/Outpatien	t_3 🗆 DO	Othe Othe	er: 4 □ Nu	ırsing Ho	me 5 ☐ Resi	dence 6	□Other (Spe	ecity)
0 [			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da)	ry y Year)	28b. Time of Injury		8c. Injury Work			28d. Describe	how injury	occurred	
Si Si		cati	2 Accident investigation				М		Yes 2 🗌					
Division	l or Attendente ofter deati	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Inju- building, etc	ury - At hor c. <i>(Specify</i>	me, farm, str )	eet, factory	, office			28f. Location ( City or To	Street and wn, State)	Number or A	lural Route Number,
	Hospitel 4 hours e Funerel C	al Ce	295 Certifier 1 X Certifying Ph	yvician: To the best	d one len w	wheeling closest	Secured	at the tree	c. data as	d obsess	and discipling	ease stell a	and or a second	e stabile
	Hospitel 24 hours 6 Funerel etely filled	edica		niner: On the basis of and manner sta	f examinati	ion and/or in	estigation	, in my of	pinion, dea	th occurr	ed at the time,	date and	place, and du	e to the cause(s)
	To the Hospitel or At within 24 hours efter d within 24 hours efter d to the Funerel Direct completely filled in by	Me	29b. Signature and title of certifier				290	. License	number			29d. Date	signed (Mon	th, Day, Year)
			Sylvin	MEDI	AL T	OUTTIE	3	RES	-00	0		MARI	CH 25	900in
-	15		30. Name and address of person who	completed cause of d	eath (Item		Print)							
			STUART AMATEAU, TH	EJOHNS HO	KING	HOOPIT!	14,60	ONO	RTHLIYO	LFE O	TREET, B	ALTIM	RE, MAI	YLAND 21287
	Str Regulate		31. Date filed (Month, Day, Year) MAR 2 8 2	32. degistr	ar's Signat	ure /	alle	)						YLMD 21287
		-	mmil a U	I WE STORM		- /								

			1 – For State Registrar	State of Ma	arylan		irtment of F		d Menta	l Hygier	211116	1 1 3 1 4
			Decedent's Name (First, Middle, La.	st)						of Death		3. Time of Death
ч	Physici		Mary 9 1	youre					Mor	rch i	72, 2006	7:05m
	/Medio Examin		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of De		4	4c. County of Death	
	Exami		Howard Cont	Game	-2	15.41	Colum	-619			Howard	
	Funeral		5. Social Security Number 6	ex 7. Ag		iast birthday)	If Under 1 Year Months Days	If Under 24 h	frs. 8. Date	of Birth	9 Birtho	lace (State or Foreign
	Director		212-58-1195	□ M 2 □ MF	88	Yrs.	Months Days	Hours	May	7 29,	1917 Mar	yland
	9		Usual Residence of Decedent		10- 0:-	. ~					1.	Od tarida Ciballinia
	sryla	٠.	10a. State 10b. County		Toc. City	y, Town or Lo					1	0d. Inside City Limits 1 X Yes 2 No
	88-1	cto	MD Howard	i		Colu						
	ith th	Director	10e. Street and Number	1 51			10f. Zip Code	1.0		10g. 0	Citizen of What Cour	ntry?
	death with the Maryland rms 23e or 28e-f show	Funeral	9443 Guilfor		FT	0 140.1	210					and the discount
		une	11. Marital Status	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔯 /		5. 13. 1	Vas Decedent of H f Yes, specify Cuba	ispanic Origin? in, Mexican, Pi	uerto Rican, e	s or No- etc.)	14. Race - Americ Black, White,	
9	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	40		Yes 2□Xio	Specify:			Specify: B	lack
21215-0036	filed within 72 hours after death with the Marylan Hygiene. ther then "naturel", or Items 23e or 28e-f show thit, the Medical Exeminational Ke natified at		15. Decedent's E			16a. Deced	lent's Usual Occup	ation		16b.	Kind of Business/Inc	dustry
<del>د</del> -	be filed within 72 ho tal Hygiene. d other then "natur event, It e Medical	Completed	(Specify only highest gra	de completed)	\	(Give	kind of work done OO NOT use retired	during most of d)	working			•
7	the second	E	Elementary/Secondary (0-12)	College (1-4or 5	0+)	Coo	k				Cafeteri	a
	A - 9 E	0	17. Father's Name (First, Middle, Last,					18. Mother's	Name (First,			
<u>a</u>	Mental Ked o	To B	John W. Bel	l				Ac	da Wis	se		
Maryland	shound N		19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	g Address (Street	and Number or	r Rural Route	Number, City	y or Town, State, Zip	Code)
	alth a		Ralph Moore- Se	on		6001	Majors	Lane	#8 Cc	olumb:	ia, MD 2	1045
Baltimore,	permit. Pages 1 and 2 should b Depertment of Health and Ments Importent: If Item 27 is marked any injury or other traumatic e		20a. Method of Disposition		20b. P	face of Dispo	sition (Name of natory or other place	ce)	Date	20c.	Location - City or To	own, State
Ē	Parit CO		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				idge Ce	1	/28/06	5 E	lkridge,	MD
======================================	Poortr		21. Signature of Funeral Service Licer	isgo		) 22	. Name and Addre	ss of Facility	Snowde	n Fu	neral Ho	me
ñ	F S E S	4	A seagle &	APP	nl	Q/ 2	46 N. W	ashino	aton s	st Roo	rkville.	мр 20850
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death	h. Do not ent	er the mode of dyin	g, such as care	diac or respira	atory arrest,		Approximate Interval Between
П	Physician		Immediate Cause (Final disease or condition	C 2.6	20	0	0	10	CI			Onset and Death
	/Medical		resulting in death)	Due to (or as	a consequ	uence of):	rece	N Car	7 —			2 ms
Н	Examiner			Cong	estiva	· He	at 1	Felore			4	lear s
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as		, , ,					0	7-3
	outec nd ransi	Examiner	that initiated events	c. Cor Due to (or as	d.m	4000	My					years
Ç	e exe	Ë	resulting in death) Last	Due to (or as	a consequ	dence of):	0					
8/60	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dical	•	d				<del> </del>				
Õ	ing pl	Mec	IF FEMALE:								1	
Box	eath certific attending p	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth	2 Fetal	Ideath 3	Ectopic pregnancy	,			23d. Date of delive Month	ery Day Year
o.	the al	sici	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	t time of de	eath 5	Other (specify)				la control	July 7 July
<u>۔</u>	that the de ed by the a detached	Physician/Me	Part II. Other significant conditions of	antibuting to doubt b		ulting in the w	adaduina anuan au	on in Dard I	224	n Did tobaco	o use contribute to the	an cause of death?
Ś	res tha signed be de		Part II. Other significant conditions of		1/ / .	uiting in the ti	idenying cause giv	en in Parti.	23	1 ☐ Yes		pably 4 Honknown
0	w require been si should t	ted	Incomonia, Ofrice	ex Fibr	Hatio	, Lad			_	1 105		
Vital Records,	has b	Completed by	Chronic Obstru	dive Pol		2 4	J. serse.		_ 248	a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
II =	The sete h	ပ္ပ	Hypertension			V.			1	performed Yes 2		2 🗀 No
/Ea	Physician: The lab. this certificate har al director, page	Be	25. Was case referred to medical examiner?	11			100		Death (Check	k only one)		
$\leq$	hysi this c	2	1 Yes 2 No	Hospital: 1 Inpatie		ER/Outpatier		4   NUISII			6 ☐Other (Specif	y)
Ē	ding P h. After t funera	-CO	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	y Year)	28b. Time of Injury	Wor		28d. De	scribe how in	ijury occurred	
<u>s</u>	tend leath lor: /	cati	2 Accident investigatio 3 Suicide 6 Could not b					Yes 2 ☐ No.				
Division of	or Attendated after death	Certification;	4 Homicide determined	28e. Place of Inj building, et	iury - At ho c. <i>(Specif</i> )	ome, farm, str	eet, factory, office			ation (Street or Town, St	and Number or Rura ate)	il Houle Number,
_	pital ours a orei [		29a. Certifier 1 ☐-€ertifying Pt	veicien: To the best	of my kno	wledge deat	2 Coourand at the time	no data and o	lace and due	to the source	Va) and manner as a	totad
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely illed in by the funeral director,	Medical		ysician: To the best niner: On the basis o and manner st	f examina							
	o the o the omple	Me	29b. Signature and title of certifier	- mainter ou			29c. Licens	e number		29d. I	Date signed (Month,	Day, Year)
,			1 12/1	7 7	20		200			70	2 / 1.	7 300
	10		30. Name and address of person who	completed cause of o	leath (Item	23a) (Tuna		120		10	lead L	4 LUCK
			F Delever	10/2	4 1	iffle	Petuzent	Pkus	. (.)	1. L.	red 2:	21044
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr			and a	0	7	7.		7
	Pogist	.0.	MAR 2 2	/1111bl /100 a		Fro LA	19 miles					

			State of Maryland / Dep	partment of Health and Mertificate of Death	-	enne 11315
		Hegistrar  1. Decedent's Name (First, Middle, Last)		71,704.0 07 2 04	2. Date of Death	3. Time of Death
Physic	ian				Month [	Day Year
/Medi		Catherine	Frances	McCagh	March 29,	Z006   Z:30 A
Exami		4a. Facility Name (If not institution, give sti	reet and number)	4b. City, Town, or Location of Death		4c. County of Death
		834 Windsor Roa	d	Cumberland		Allegany
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birthplace (State or Foreign Country)
Director		215-20-5120	M 2 🕅 F 82 Yrs.	Months Days Hours Will.	12/25/192	Maryland
B		Usual Residence of Decedent				
ylan,		10a. State 10b. County	10c. City, Town or L	cocation		10d. Inside City Limits
Mar Mar	ţ	MD Allegar	C. C.	umberland		1X Yes 2 □ No
the 28a	Je C	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
with a or	Funeral Director	834 Windsor F	Road	21502		USA
s 23	Fra				acity Vas or No-	14. Race - American Indian,
er de Item	5	11. Wanta Status	Amed Forces?	. Was Decedent of Hispanic Origin? (St If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
s aft	by F	1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🖾 No If Yes, Give	1 ☐ Yes 2 X No Specify:		Specify:
noor Je	9		Year or Dates:		1.0	White
nat dies	ete	15. Decedent's Educa (Specify only highest grade	completed) (Giv	edent's Usual Occupation be kind of work done during most of work	king 160.	Kind of Business/Industry
	lg i	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		
w be w w w w w w w w w w w w w w w w w w	Completed	12		Homemaker		Home
soft is	Be	17. Father's Name (First, Middle, Last)			ne (First, Middle, Maid	· ·
Alenti Alenti rked tice	10	Grover	Cleveland Blan	ke Edith	ı De	evona Larkin
Is a year to 2.12.15.7000 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene Is marked other than "natural", or Items 23a or 28a-f show aumetic event, the Medical Evacit metrical be rediffed at	1	19a. Informant's Name/Relationship (Type	e, Print) 19b. Mai	ling Address (Street and Number or Ru	ral Route Number, Cit	y or Town, State, Zip Code)
peritinition of the first property of the first period of the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event intermed to recitive an any injury or other traumatic event, the Medical Event intermed to once.		Brian McCagh / sor	1423	2 Bradshaw Drive,	Silver Spi	ring, MD 20905
Hee tem		20a. Method of Disposition	20b. Place of Disp	position (Name of ematory or other place)	Date 20c.	Location - City or Town, State
ages nt of t: If i		1 Burial 2 Cremation 3 Re	movar from State		101 /2006	Complement MD
it. P rtme rtan njury		'4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licenses		ter & Paul Cem. 04		
Depa Depa mpo mny in		21. Signature of Juneral Service Licenses			CONTRACTOR OF THE STATE OF THE	Funeral Home, P.A.
9 205 8 9		Lakest C. C	dem	404 Decatur Stree		
		23a. art1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do not elections on each line.	/	1	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	Chionic Obs	tructive pul	monary	Sispasi Surais
/Medical		resulting in death)	Due to (or as a consequence of):	4	,	
Examiner						
	ē	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):			
uted	声	Cause (Disease or injury				
be executed ician and burial-transit	Examiner	resulting in death) Last	Due to (or as a consequence of):			
w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	call					
difficate g phys	edic	8.				
A ding	Me	IF FEMALE:	c. If yes, outcome of pregnancy			23d. Date of delivery
ath cer titendir	an	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2☐Fetal death 3	Ectopic pregnancy		Month Day Year
e de the a	Sic	1 ☐ Yes 2 ▼ No 9 ☐ Unknown	4☐Pregnant at time of death 5 9☐Unknown	Other (specify)		
The law requires that the death certifical the bas been signed by the attending phoage 2 should be detached for use as it.	Physiclan/M			and the second of Dead	22a Did tehaca	to use contribute to the cause of death?
gner gner	þ	Part II. Other significant conditions cont	nbuting to death but not resulting in the	underlying cause given in Part I.		2 No 3 Probably 4 Unknown
w requires to be signed should be	ed				T Tes	2 No 3 Plobably 4 Molikilowii
aw re s be	ompleted				24a. Was an autopsy	24b. Were autopsy findings available
he la e ha	E				performed	
	Ö	25. Was case referred to medical		26 Place of Dea	th (Check only one)	140 12110
ding Phyaician: h. After this certific funeral director,	o B	eyaminer?	spital: 1 Inpatient 2 ER/Outpatie			6 ☐Other (Specify)
P F	-	27. Manner of Death	28a. Date of Injury 28b. Time		28d. Describe how in	
nding ath. 7: Afte e fune	5	1 Natural 5 ☐ Pending	(Month, Day Year) Injury	Work? M 1 □ Yes 2 □ No		
Attending r death. sctor: After by the fune	ca	3 Suicide 6 Could not be	29a Place of Injury - At home form		28f Location (Street	and Number or Rural Route Number,
or A fiter jirac	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, s building, etc. (Specily)	street, factory, office	City or Town, St	
Lurs a		***			<u> </u>	
Hosp 4 hou Fune ely fii	Ca		cian: To the best of my knowledge, dea er: On the basis of examination and/or			
To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the t	Medical	one)	and manner stated.			
To t To t	Σ	29b. Signature and title of certifier	(///	29c. License number		Date signed (Month, Day, Year)
5		•	H	D0059479		March 29, 2006
		30. Name and address of person who cor	npleted cause of death (Item 23a) (Type	e, Print)		
mes		George Henna	wi. M.D., 925 Bis	shop Walsh Drive,	Cumberland	. MD 21502
S	tate	31. Date filed (Month, Day, Year)	32. Regispar's Signature	books		
		MAR 3 1 2	TITLE & BEA A	#7 - #1 h		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Donald Ray Metz MARCH 25 2006 1940 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner ALLEGANY MEMORIAL HOSPITAL CUMBERLAND If Under 1 Year II Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1**X** M 2□ F 216-74-9143 Yrs Director 68 14,1937 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: if item 27 is marked other then "natural", or items 23s or 28s-f show ury or other traumatic event, the Medical Examinations in Item and Iffed at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Allegany Cumberland Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 600 Furnace St. 21502 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disability Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Howard Metz Cora (Sweitzer) Metz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Halle Legal Guardian 12309 Bowling St., Cumberland, MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) New Germany Meth Cem 30 06 New Germany, MD permit. Page Department of Important: If any injury or once. 22. Name and Address of Facility Hafer Funeral Service, 1302 National Hwy., LaVale, MD 21502 23a. Part1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CPSIS Unknown /Medical Due th (or as a consequence of): Examiner neumonio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) for use as the burial-transit Hospital or Attending Physician: The law requires thet the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Disorder Mental Retardation. 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown Failure, Anemia, Gastroesophaguela. Was an autopsy perform, 24b. Were autopsy lindings available prior to completion of cause of death?

1 Yes 2 No Reflex Disease Urinary Tract Infection 2 **K** No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 

Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ▼No this filled in by the funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) I. MALIK Do0 59121 MARCH 27 2006

71 dd State

Registrar

30. Name and address of person

31. Date liled (Month, Day, Year)

Malik

MAR 2 8 2006

ORIGINAL

Medical Bldg, Cumberland, MD 21502

who completed cause of death (Item 23a) (Type, Print)

🐲. Registrar's Signature

Johnson

Height

Amended Item 1 per Physician 03/31/2006 Carroll County, will Amended Item 26 per Physician 03/29/2006 Carroll County, will Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death Time of Death Month Year Lucille Lorraine Mayne **Physician** 6:30 AM -Lorraine Lucille 28 2006 March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7110 Woodbine Road Woodbine Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
(Month, Pay, Year)
July 2, 1930 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days 1 M 2 X Hours Months 214-26-0623 75 Director Usual Residence of Decedent with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show other traumatic event, the Mudical Examiner nust be nutified at MD Carroll 1 ☐ Yes 2 ☑ No Mt. Airy Director 10g Citizen of What Country? 10e. Street and Number 10f. Zip Code 2518 Flagmarsh Road 21771 Items 23e United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should ba filed within 72 hours after c Department of Health and Mantai Hygiene. I more important: If item 27 is marked othar then "natural", or Item any injury or other traumatic event Black, White, etc. 1 ☐ Yes 2 1 Never Married 2 Married 2(XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. þ White 3 XWidowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Service Howard Co. Schools 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Harry Eldridge Bloom Katherine Lovina Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Virginia Arnold Daughter 7110 Woodbine Road Woodbine, MD 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Poplar Springs Cem. 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State Mar. 31, 2006 Poplar Springs, MD 4 ☐ Conation 5 ☐ Other (Specify) 22. Name and Address of Facility 1212 W. Old Liberty Road 21784 of Funeral Service Licensee 21. Sign Trul Burrier-Queen Funeral Home & Crematory PA Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on eachline. Approximate Interval Between Onset and Death 23a. Part1. shock Immediate Cause (Final disease or condition resulting in death) Meta Priysician Y /Medical Due to (or as a consequence of): **Examiner** Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit Due to (or as a consequence of). attending physician Division of Vital Records, P.O. Box 68760. Physician/Medical as the t IF FEMALE: 980 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Daughter's Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 2 No 6 XOther (Specify) Residence ို 1 🗌 Yes 27. Magner of Seath 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of al or Attending P safter death. I Diractor: After t Certification; Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Fo the Hospital within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 skander, MD E/hamy E 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of I	Maryland		artmen tificate			and M		Reg. No.	006	11318
	Dhysiai	20	1. Decedent's Name (First, Middle,								2. Date of Dea	ath	2006 <sup>Year</sup>	3. Time of Death
	Physici: /Medic		Alfred John Mar				011			(0, 1)	0.3		County of Death	11:29 AM
4	Examin	er	4a. Facility Name (If not institution,		er)			n P	Location o	or Death			Norcest	
	F		6 Knight Terrace 5. Social Security Number		Age (In yrs. las	t birthday)	If Under	1 Year	If Under		8. Date of Birt	h	9. Birth	nplace (State or Foreign
	Funeral Director		156-24-0412	XIX M 2□F	72	Yrs.	Months	Days	Hours	Min.	(Month, Da 12/07/	1933	Col	nplace (State or Foreign untry) NJ
	pu ,		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Tour or Lo	antion							10d. Inside City Limits
	ehov	ក	MD Worces	tor	Ocean									1 ☐ Yes 2XXNo
	28a-1	rect	10e. Street and Number	Cer	occan		10f. Zip	Code				10g. Citize	en of What Co	untry?
	3a or	Funeral Director	6 Knight Terra	ce			218	311				1	USA	
	death ims 2	nera	11. Marital Status	12. Was Decede	ent Ever in U.S.	13.	Was Deced	lent of Hi	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	- 1	4. Race - Ame Black, White	
9	or Its	F	1 Never Married XX Marrie	d XXYes 2 If Yes, Give	□No es: 1950–5	. 5	1 Yes		Specify:	,, , , , , , , , , , , , , , , , , , , ,			Specify: Whi	
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Itams 23e or 28e-f ehow the Madical Exercitins must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's				dent's Usua		ation			16h Kin	d of Business/	Industry
7	in 72	Completed	(Specify only highest	grade completed)		(Give	kind of woi	rk done d se retired	furing mos	t of worki	ng	TOD. TAIL	d of Eddinosar	industry .
212	iene.	E	Elementary/Secondary (0-12)	College (1-4	or 5+)	Elec	tricia	an				Con	structi	Lon
b	al Hyg	Be C	17. Father's Name (First, Middle, La								(First, Middle,	Maiden S	Sumame)	
<u>ya</u>	Ments arked atice	ပို	Alfred John Mar						Daisy					
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 le marked other then "natural; or Itams 23a or 28a-1 show apprintury or other traumatic event, the Macical Examinet must be notified at once.	8	19a. Informant's Name/Relationshi								Pines,			(ip Code)
e,	1 and Healt em 2:		Doris Marchese 20a. Method of Disposition	(MIIE)			osition (Nari				ate		ation - City or	Town, State
п	ages ant of it: If it y or o	-	1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		alu		natory or o e K <b>i</b> n	_	۱ ۵	3/31	/2006	Fran	klin La	akes, NJ
Baltimore,	antime portan		21. Signature of Funeral Service Li							by Bur	bage Fu	ınera	1 Home	
ä	Departing Department of the partment of the pa		Vacameline	4. Bo	exporty	1	08 Wi	11 <b>i</b> a	m Str	eet	Berlin,	, MD	21811	
			23a. Part1. Enterthe disease, or conscious shock, or heart failure. List of	omplications that cau	used the death.	Do not en	ter the mod	le of dyin	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	_a Lung	Cancer									6 Months
1	/Medical Examiner		resulting in death)		r as a conseque									10 Years
		-6	Sequentially list conditions,	D	inson's		ase							10 10015
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events											
o o	an and rial-tra	Exa	resulting in death) Last	Due to (or	r as a conseque	ince of):								
3760,	death certificate be executed e attending physician and of for use as the burial-transit	cal		d										
K 68	ertifica ling ph e as th	Physician/Med	IF FEMALE:	22 - 14					-					
Вох	leath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		ome of pregnanc th 2 ☐ Fetal d nt at time of dea	leath 3[	Ectopic p					2	3d. Date of del Month	Day Year
P.O.	y the a	iyslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow		un 5	_ Ou 161 (s):	ecity)						
	requires that the death een signed by the atten hould be detached for u	by Ph	Part II. Other significant condition	s contributing to dea	ith but not result	ing in the u	ınderlying c	ause giv	en in Part I	١.	23e. Did t	obacco us	se contribute to	the cause of death?
Records,	quires an sign uld be	d ba									1 🗆	Yes 2 🖺	No 3□Pr	robably 4 Unknown
000		Completed									24a. Was		24b. Were at	utopsy findings available completion of cause of
æ	The ate h page	E O									perfo	rmed? 2 M No	death?	-
Vital	clan: ertifica	Be (	25. Was case referred to medical examiner?					100		e of Deat	h (Check only	one)		
of \	Physiclan: this certificated frail director, it	၉	1 ☐ Yes 2 🗹 No			R/Outpatie			4 🗆 NI	ursing Ho	me 5 Resi 28d. Describe		Other (Spe	cify)
NO.	ding F h. After funer	lo Lo	27. Manper of Death  1 Natural 5 Pending 2 Accident investig		, Day Year)	Injury	M	28c. Injur Wor	k? Yes 2 🗀		200. Describe	now injury	occurred	
Division	Attending r death.	flca	3 ☐ Suicide 6 ☐ Could no	ot be 28e, Place o	of Injury - At hom	ne, farm, st								ural Route Number,
ō	al or / s after I Dire	Fri	4  Homicide	building	g, etc. (Specify)			I			City or To	wn, State)		
	To the Hoepital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical Certification;	(Check only 2 Medical E	Physician: To the bixaminer: On the bas	sis of examination	ledge, dea on and/or in	th occurred rvestigation	at the tir	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
	thin 2 the l	Med	one)  29b. Signature/and title of dertifier	and manne	er stated.		29	c. Licens	e number			29d. Date	e signed (Mont	th, Day, Year)
	To To		► 11 \11 1ii	1/	200	- KII		0-35					/26/200	
			30. Name and address of person v	who completed cause	of death (Item	23a) (Type	Print)							
8:1	1011		William T. Gree	r III MD 1	L2417 Oc	ean (	Gatewa	ay S	uite	5A 0	cean Ci	ty, l	MD 2184	2
		ate	31. Date filed (Month, Day, Year)	8 2006 <sup>32. F</sup>	gistrar's Signatu	The state of	bed	1						
	Regist	rar	MAR 2	V - 2000 - A	CONTO 1	~ /	-							

			For State Registrar	State of Ma	ryland				ealth a Death	and M		Reg. N	UUD	11319
Ph	ysicia	an .	Decedent's Name (First, Middle, Last								2. Date of Dea	Da		3. Time of Death
//	Medic	al .	MARIAN GRACE MORT				45 035	T	. 1	4 Denth	03	24	2006 c. County of Dea	3:23 A M
Ex	amin	er	4e. Facility Name (If not institution, give				4D. City		Location of			-	WICOM:	
Fun	ieral		220 N. CLAIRMONT  5. Social Security Number 6. S		(In yrs. las	t birthday)		r 1 Year	If Under	24 Hrs.	8. Date of Birt	h	9. Bir	thplace (State or Foreign
	ctor		217-14-8421	□M 2[ <b>X</b> F	91	Yrs.	Months	Days	Hours	Min.	(Month, Da 10-14-			CIMORE, MD.
pur	27		Usual Residence of Decedent  10a. State 10b. County		10c. City. 7	Town or Lo	cation							10d. Inside City Limits
Manyle f sho	E N	ō	MD WICOMI			LISBU								1√2 Yes 2 □ No
the 1	He le	Director	10e. Street and Number	1		ПТОВС		Code				10g. C	itizen of What C	ountry?
h with	ad la	a D	220 N. CLAIRMONT	AVENUE				218	301				USA	A
r deal	BECHI	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. \	Vas Dece Yes, spe	dent of Hi	ispanic Orig	gin? (Spe	cify Yes or No Rican, etc.)	-	14. Race - Am Black, Whi	
s afte	e e	by F.	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	0		I □ Yes		Specify:					HITE
IC CICIO-0000 filed within 72 hours after death with the Maryland I Hygiene. other than "natural", or Items 23a or 28a-f show	Sal Ex		15. Decedent's Ed			16a. Deced	lent's Usu	al Occupa	ation			16b. i	Kind of Business	
hin 72 in 10 in 12 in 10 in 12 in 10 in 12	Media	Completed	(Specify only highest gra	de completed) College (1-4or 5+		(Give lite. L	kind of wo	ork doné d ise retired	during most	t of workii	ng			,
My with	2	Com	12	2		F	OMEM	AKER					WN HOME	
VIGILU CIC buld be filed with Mental Hygiene. arked other than	eveni	Be	17. Father's Name (First, Middle, Last)								(First, Middle,	Maide	n Sumame)	
should be nd Mental	natic	2	WILLIAM H. MORTON  19a. Informant's Name/Relationship			10h Mailie	a Addeon	- (Stroot	EDNA			or City	or Town, State,	Zin Coda)
d 2 shoth thand	traur		LISA SCHROCK - FR				-					-		AND 21871
s 1 and 27 tem 27	other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition			e of Dispo					ate		ocation - City or	
Pages nent of int: If it	ry or		1 🔀 Bunal 2 ☐ Cremation 3 ☐  1 4 ☐ Donation 5 ☐ Other (Specify			MICO				3-29-	-2006	SAL	ISBURY,	MARYLAND
Dallillor permit. Pages Department of important: If it	eny injury or otha		21. Signature of Funeral Service Liger	ISBB RII	,								L HOME,	
0 88 E	2 g		Million Help	of Wille	₹	70	)5 EA	ST M	AIN S	TREE'	Γ,SALIS	BUR		AND 21804
	v		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused to one cause on each line	the death. e.	Do not ent	er the mo	de of dyin	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
Physic /Med			Immediate Cause (Final disease or condition resulting in death)		myco									years
Exam				Due to (or as a	consequer	nce ot);/								
A P	-4.4	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequer	nce of):								
cuted	transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c						<u>_</u>				
fou, e be exe sician a	the burial-transit	I Ex	resulting in death) Last	Due to (or as a	consequer	nce of):								
Of VILAI necords, F.O. BOX 00/00, Physicien: The law requires that the death certificate be executed this certificate has been signed by the attending physician and	the	edical		d										
ath certific	use as	√/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of									23d. Date of de	olivery
death death	d for a	Iclar	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t			Ectopic p Other (s	regnancy pecify)					Month	Day Year
by the by	tache	Physician/M	9 Unknown	9□ Unknown										
es the	should be detached for use as the	þ	Part II. Dther significant conditions of	ontributing to death bu	t not resulti	ng in the u	nderlying	cause give	en in Part I.				,	o the cause of death?
w requires been sign	hould	Completed									101			
e law	CA	mpk									24a. Was autop perio		prior to	utopsy findings available completion of cause of
VILAI F iician: Th certificate	ır, paç	e Co	25. Was case referred to medical						00.01		1 Yes	2 N		s 2 No
VILAI rsician: 1 s certifical	directo	0 8	examiner?	Hospital:	nt 2∏FF	NOutpatien	t 3 D	OA Othe	00	rsing Hor	ne 511 Besid		6 ☐Other (Spe	acify)
JII OI ding Phys	oeral (	on: T	27. Manner of Death	28a. Date of Injury (Month, Day		Bb. Time of Injury		28c. Injun			28d. Describe I			,
SIOII tending death. tor: Afte	he fur	atlc	1 Natural 5 Pending 2 Accident investigation	1		,,	М		Yes 2 □I	No				
or Att	n by t	Certificat	3 Suicide 6 Could not be determined		ry - At hom. . (Specify)	e, farm, str	eet, factor	y, office		2	28f. Location (S City or Tox			lural Route Number,
UIVISION  To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After	completely filled in by the funeral director, page	al Ce	29a. Certifier 1 Certifying Ph	ysician: To the best o	f my knowle	edge death	Occurred	l at the tim	ne date an	d place 3	and due to the	Causol	c) and manner a	e stated
24 hc	letely	edica	(Check only 2 Medical Exer	niner: On the basis of and manner stat	examination	n and/or in	estigation	n, in my o	pinion, dea	th occurre	ed at the time,	date ar	nd place, and du	e to the cause(s)
To th Within To th	comp	Me	29b. Signature and title of certifier				29		e number				ate signed (Mon	
15	00		- Jama luins					Dool	5995			3	124/06	
noc	4		30. Name and address of person who	completed cause of de	ath (Item 2	3a) (Type,	Print)	۲.	2 00	04.4	F 1.1		124/06 No 2180	. 1
1			JANE A. (LICK 31. Date filed (Month, Day, Year)	32. Begistra	r's Signatur	curside	Dr	, Jul	Ta HI	Ly	しついいか	my.	MO 2180	1
R	Sta egistr		MAR 2 7 2		. 5 Orginaldi									

DHMH 17 Rev 1/2001

ORIGINAL

			riease i			ortmost of Health and	_		
			1 _ State	State of Marylar	-	artment of Health and <i>rtificate of Death</i>		2.000	11320
	5.1 1.6		Registrar  1. Decedent's Name (First, Middle, Last,			Tuncale of Dealit	2. Date of Death	g. No.	2 Time of Death
	Physici	an	T		MC	DAN. 51=	Month ,	Day O Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give	Street and number)	10/	4b. City, Town, or Location of De	March	4c. County of Death	
	Examir	ier	Manakin Mar	M		Princessann	0	Some	1
	Funeral		Social Security Number     6. Security Number		last birthday,			9. Birth	place (State or Foreign
	Director		219-92-5256	M 20F 63	3 Yrs.	Months Days Hours N	lin. (Month, Day,	3-42	intry) MD
	p s		Usual Residence of Decedent  10a. State 10b. County	10c Ci	ty, Town or L	ocation			10d. Inside City Limits
	•ho	ō	4.1						1 X Yes 2 □ No
	the M	Director	10e. Street and Number	1100	SAL	ISBURY	1.10	) - Citizen of Miles Co	
	ours after death with the Maryland rai', or itema 23a or 28a-f ehow Exerpling in the Foldling at	Ö	710 0	5-		71701	10	og. Citizen of What Cou USA	muy?
	leath	Funerail	11. Marital Status	12. Was Decedent Ever in U	I.S. 13.	Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - Ameri	ican Indian.
(0		필	Never Married 2 Married	Amed Forces? 1 ☐ Yes 2 No If Yes, Give		Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	rerto Rican, etc.)	Black, White	
03	hours after turai', or ite	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give / Year or Dates:		1 ☐ Yes 2 No Specify:		Specify: B	Lack
Maryland 21215-0036	72 hours "natural", dicul En	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a. Dece	dent's Usual Occupation kind of work done during most of	working 1	6b. Kind of Business/In	ndustry
21		dr.	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	.1	Dank	4 1 2
2	fited within I Hygiene. other than	S	17.5 11.1 11.1 11.1		C1	TICKEN CATC	HER	PERD	UE
anc		Ве	17. Father's Name (First, Middle, Last)	(D)		18. Mothers i	Vame (First, Middle, M	naiden Surname)	
ž	hould be id Menta marked matic ev	၉	19a. Informant's Name/Relationship	DANIEL	10h 34mili	ng Address (Street and Number or	CIE W	ILSON	- 0
Z	s 1 and 2 should I Health and Mer Item 27 is marke other traumatic		about the services	•	710	ng Address (Street and Number of		City or Town, State, 21	-1 4 1
	f Heal item 2	9	MARY LUATKINS	~ SISTER	Place of Dispo	osition (Name of	Date Date	0c. Location - City or T	own, State
Baltimore,	0 0		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		matory or other place)	1.100 -	D	E MD
Ħ	ermit. Pag epartment nportant: I ny injury o		21. Signature of Funeral Service License	90	IRIST 1	2. Name and Address of Facility	BENNIE	SMITH F	11/10
ä	Departr Departr Imports any inju		Miseilla	Kound a)	q	17-11) TOARE	1A ST S	AUSBURU	Mn 21801
3# **	20,99		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the deal	th. Do not en	er the mode of dying, such as card			Approximate Interval Between
, II	Physician		Immediate Cause (Final	to cause on each since	1/	scular De		,	Onset and Death
	/Medical	1	disease or condition resulting in death)	Due to (or as a conse	uence of):	received to	mence	2	2 yrs
4	Examiner		e di cara di c	,					
	ם ב	ner	Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consec	quence of):				
	ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last						
760,	be execu ician and burial-tra		rooding in doding Edge	Due to (or as a conseq	luence of):				
687	0 0 0	dicai							
9 ×	certifica Iding phi Ise as th	Me	IF FEMALE:	3c. If yes, outcome of pregna	ancy				
Вох	death e e atten	cian	in the past 12 months?	1 ☐Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	Il death 3	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	ery Day Year
o.	that the de ed by the detached	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	, out.	Other (appeary)			
<u>α</u>	requires that the een signed by th hould be detache	Y P	Part II. Other significant conditions con	tributing to death but not res	sulting in the u	nderlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	w requires been sig should b	Completed by	Alureseelabl	e Sigmoux	Cel	en Cance	2 1 □ Yes	s 2∭No 3∏Pro	bably 4 Unknown
00		ojet	Essential	Hypery	Lens	in	24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
R	sician: The law certificete has t irector, page 2 s	Eo	Streke wit	16 A300 0	Rlan	uparesis	autopsy perform	ed? death?	ompletion of cause of 2 <b>⊠</b> No
Vital	ysician: is certifice director, p	Bec	25. Was case referred to medical examiner?	a distance	40,7		Death (Check only one	-	
of V	Physician: this certific al director,	2	1 ☐ Yes 2 No	ospital: 1   Inpatient 2	ER/Outpaties	nt 3□ DOA Other: 4₺ Nursin	g Home 5 ☐ Resider	nce 6 Other (Speci	fy)
2	ng P	e :	27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury at Work?	28d. Describe hov	w injury occurred	
sio	Attending ir death. ector: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			M 1 Yes 2 No			
Division	or At fter d Direct in by	Certification;	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specifical Control of the Control of	ome, farm, sti by)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	pital burs a erai i filled		29a. Certifier 1 Certifying Phys	iniana. To the heat of my loo	vuladas dask				
	24 hc	Medicai	(Check only one)	ner: On the basis of examina and manner stated.	ition and/or in	h occurred at the time, date and play vestigation, in my opinion, death of	ice, and due to the call courred at the time, dat	use(s) and manner as s te and place, and due t	o the cause(s)
	To the Hospital or Attending F within 24 hours after death.  To the Funeral Director: After completely filled in by the funer.	Me	29b. Signature and title of certifier			29c. License number	29	d. Date signed (Month,	Day, Year)
	VA,	H	Meserio Va.	Belle	all	D 29509	- 5	march 2	4,2006
\	1 yr		30. Name and address of person who co			Print)			
	10		GREGORIO M. B			2 CHINABERRY I	R. SALISB	URY, MD 2	21801
		te -	31. Date filed (Month, Day, Year)  MAR 2 8 20	32. Ragistrar's Signa					

DHMH 17 Rev 1/2001

March 33, 2006 850pm

James McDaniels

NLM Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27 pen/F, 9856,67706 TT State of Maryland / Department of Health and Mental Hygiene 06-2273 Fransisco Morales 1 - State Registrer Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day Month **Physician** Francisco Ž<u>,</u> 2006 Rolando Reynoso Morales April 5:56 A M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Kent Chester River Hospital Center Chestertown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 01/25/1972 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex **Funeral** 1**X**M 2□F none 34 Vrs Guatemala Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County rthan "natural", or itama 23a or 28e-f show the Madical Examiner must be notified at 1 ☐ Yes 2 No Director MD Caroline Marydel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3801 Barclay Road 21649 Guatemala 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 □ No Specify: Guatemalan Specify: Hispanic ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Assemblyman Manufacturing 0618. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 end 2 should be fill ment of Health and Mental H lent: If item 27 is marked other. María Victoria Morales Gabriel José Antonio Reynoso González 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Macario Perez Juarez/brother-law 3801 Barclay Road; Marydel, MD 21649 20b. Place of Disposition (Name of cemetery, grematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1. Burial 2 □ Cremation 3 □ Removal from State Caserio Villanueva 5 Department of Importent: If sny injury or once. Twichilel Cemetery NA 4 ☐ Donation 5 ☐ Other (Specify) Guatemala 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Helfenbein Funeral Home, PA Greensboro, MD 21639 -Con Approximate Interval Between Onset and Death 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac arrhythmia /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical use as the attending for use as 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) signed by the aid 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No o 9 Unknown 9 Hinknown Δ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown certificate hes been s rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 2 \ No 2 🗌 No of Vital Attending Physician: after death.

Director: Alter this certific 25. Was case referred to medical examiner? Medicai Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYYes 2 ☐ No 1 🗌 Inpatient 2X ER/Outpatient 3 □ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours aft To the Funerel DI completely filled in To the Hospitel 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title 29c. License number 29d. Date signed (Month, Dey, Year) April 2, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year) APR 1 1 2006

32. Registrar's Signature

		Amend Item	S23a opelen	Henge 83		<b>706ti</b>	ith an			e (1) (1) G	1132	22
Physic /Medi	cal	1. Decedent's Name (First, Middle, Last)  MAKSULE  4a. Facility Name (If not institution, give str	A NN		MILLE 4b. City		_ocation of E	2. Date of Month MAVLI	7 22	Year 200 V	1137	Death M
Examil Funeral Director	ner	UNIVERSATY OF M 5. Social Security Number 6. Sex	ARULANI 7. Age (II	n yrs. last birth	Br	TT 14	I Under 24	C1721	Birth Day, Year	9. B	inthplace (State or Country)	r Foreigi
e Maryland Sa-f ehow	Director	Usual Residence of Decedent           10a. State         10b. County           MARYLAND         CHARLE		c. City, Town	ISLAN						10d. Inside City	
th with th		10e. Street and Number 12101 NEALE SOUN	ND DRIVE			2062				U.S.A	•	
72 hours after death with the Maryland naturel; or itema 23a or 28a-f ehow lical Exeminat must be nutified at	by Funeral	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	<ol> <li>Was Decedent Eve Armed Forces?</li> <li>1 ☐ Yes 2 X No If Yes, Give Year or Dates:</li> </ol>	r in U.S.	13. Was Dece If Yes, spe 1  Yes		panic Origin , Mexican, F Specify:	? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - An Black, Wh Specify: W		
d within 72 hours after death with the Marylan jiene. r than "naturel", or itema 23e or 28a-f ehow the Medical Exemples must be nutified at	Completed	15. Decedent's Educa (Specify only highest grade Elementary/Secondary (0-12) 1 2			Decedent's Usu Give kind of wo life. DO NOT u	ork done di se retired)	uring most of	working		Kind of Busines	s/Industry	/ T.C.F
be file tal Hyg d othe	To Be Co	17. Father's Name (First, Middle, Last) THOMAS CARTER		,			MARG		dle, Maide	n Sumame) CH		
		19a. Informant's Name/Relationship (Typ. PAUL MILLER-HUS 20a. Method of Disposition	SBAND	12	2101 NE	EALE	SOUN	D DR • , C	OBB		D,MD 20	)625
permit. Pages 1 ar Department of Hes important: if item any injury or othe once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Juneral Service Licensee	ANI	-	CHAPEL  22. Name at RAYMO	CEM	s of Facility	-29-06 AL SERV		-500-5-5000	VIRGIN	UA.
Physician		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	ations that caused the cause on each line.	e death. Do no	LA PI	ATA de of aying	MAR , such as ca	YLAND 2 rdiac of respirator	064 ( y arrest,	5	Approximate Interval Betw Onset and D	ween
The law requires that the death certificate be executed was been signed by the attending physicien and page 2 should be detached for use as the burial-transit	lical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a c	ibular onsequence o	Necrosi	s ( <i>I</i>	ATN)					
hat the death certificate dby the attending physietached for use as the	Physician/Medi	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2/□ No 9 ☐ Unknown	ic. If yes, outcome of 1 Live birth 2 (4 Pregnant at time 9 Unknown	Fetal death	3 □Ectopic p 5 □ Other (s				_	23d. Date of o Month		Year
requires that been signed b		Part II. Other significant conditions cont	ributing to death but r	not resulting in	the underlying	cause give	n in Part I.				to the cause of d	
	Completed by							24a. W a p 1 □ Y€	utopsy erformed?	prior t death	autopsy findings a completion of ca ? es 2 \( \square\) No	available ause of
nding Physician: Th th.: After this certificate e funeral director, pag	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2500  27. Manner of Death  1 Statural 5 Pending 2 Accident investigation	28a. Date of fnjury (Month, Day Y	28b. T		28c. Injury Work	4 🗆 Nurs		lesidence	6 □Other (Si	pecify)	
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of fnjury building, etc. (	(Specify)				City or	Town, Sta	ite)	Rural Route Num	ber.
To the Hospita within 24 hours To the Funeral completely filled	Medical	(Check only 2 Medical Examin	er: On the best of e and manner state	camination and	Vor investigation	n, in my op	inion, death		ne, date a	nd place, and d	lue to the cause(s	;)
To To Con	2	29b. Signature and title of certifier	l		•		190		Ma	vcu 23,		
18		30. Name and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person who could be seen and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person address of person and address of person address of pe	npleted cause of dea		1ype, Print) 22 500	MA	aree	ME STK	EET	BAL	DMUKE T	2120
S Regis	tate trar	APR 1 0 2006			A# -							

ORIGINAL

			1 - For State of Maryland / Dep. Registrar Ce	artment of Health and M rtificate of Death	ental Hygien	CACII GUU.
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia		Virginia Elizabeth Moss			2006 Year 6:10 P.M
}	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
	LXaiiiii	C.	Calvert Manor Health Care Center	Rising Sun		Cecil
	Funeral		Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
	Director		443-22-4932 1 M 20XF 79 Yrs.	Months Days Hours Min.	Oct. 8, 19	26 Oklahoma
	D		Usual Residence of Decedent			
	how		10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
	a Ma	cto	MD Harford Havre of	de Grace		1 ☐ Yes 2 🔯 No
	th th or 28 e no	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	th w	a	113 N. Earlton Rd.Ext.	21078		U.S.A.
	ams ams	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I	cify Yes or No- Rican, etc.)	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
92	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-f ehow in Medical Exercit er is ust be neitified at	γFι	1 □ Never Married 2 □ Married 1 □ Yes 2 💆 No If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: White
21215-0036	ural',	d by				WILCE
7	"nat	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of worki DO NOT use retired)	ng 16b.	Kind of Business/Industry
7	withir	ם	Elementary/Secondary (0-12) College (1-4or 5+)	nemaker		n Home
7	Hygie Ther nt, I	e Co	12 0 FIQI		(First, Middle, Maide	
an	d be	<b>B</b>	Virgil Reed	Marie		···-··-,
Maryland	mark	2	19a, Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rura	l Route Number, City	or Town, State, Zip Code)
<u>S</u>	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-1 ehow any injury or other traumatic event, If a Medical Exercitest crust be notified at once.			N. Earlton Rd. Ext.		
တ်	s 1 and 2 of Health a Itam 27 is other trac		20a. Method of Disposition 20b. Place of Dispo		ate 20c.	Location - City or Town, State
ē	ages int of t: If I		1 Buriai 2 Cremation 3 Memoval from State	matory or other place) Mem. Gdns. 4/7/0	na Aba	rdeen, Maryland
Baltimore,	artme ortan injury					
Ba	Depa Impo any is		Mua Bellman	2. Name and Address of Facility Carring-Cargo Fune: Aberdeen, Maryland	ral Home. 21001-33	99 <sup>A</sup> .
1	ř		23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Ι.	Physician <sub>1</sub>		Immediate Cause (Final	D. 1		Onset and Death
-	/Medical		disease or condition resulting in death)  Due to (or as a consequence of):	Mikny		
	Examiner		Pautinson's	Disease		
٠,		Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying.  Due to (or as a consequence of):			
ব্ৰ	cu ed	ami	causé. Enter Underlying Cause (Disease or injury that infriated events c.			
ó	e exe lan a urial-1	E	resulting in death) Last Due to (or as a consequence of):			
8760,	death certificate be execu ed e attending physician and od for use as the burial-transit	dical Examiner	d			
9	entific ling p	Mec	IF FEMALE:			
Вох	ath co	ian/		Ectopic pregnancy		23d. Date of delivery  Month Day Year
0	that the death certific ed by the attending p detached for use as	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)		
٥.	The law requires that the te has been signed by the bage 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I	23e. Did tobacco	use contribute to the cause of death?
Records,	signed be del	1 by			1 ☐ Yes	2 No 3 Probably 4 Unknown
Ö	w requir been si should l	etec				
Sec.	e law hast	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
<u> </u>		S			1□ Yes 2X	
<u> </u>	Physician: Th this certificate al director, pag	Be	25. Was case referred to medical examiner?	26. Place of Death	-	
ot	Phye this al di	. To	1 Tyes 2 No 10 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of Injury 28b. Time of	nt 3 DOA Sursing Hor	me 5 Residence 28d. Describe how in	6 ☐Other (Specify)
U O	ding I After funer	lo l	Natural 5 ☐ Pending (Month, Day Year) Injury	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	Edg. Describe now in	ary occurred
<u>S</u>	Attending Physician: or death. actor: After this certifically the funeral director.	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st		28f Location (Street:	and Number or Rural Route Number,
Division of Vital	l or Attendater death Diractor:	Certification;	4 Homicide determined building, etc. (Specify)	reet, factory, office	City or Town, Sta	
	spita nours neral		29a. Certifier Certifying Physician: To the best of my knowledge, deal			
	To the Hospital or Attending I within 24 hours after death. To tha Funeral Diractor: After completely filled in by the funer	edical	(Check only 2 Medical Exeminer: On the basis of examination and/or in	ivestigation, in my opinion, death occurre	ed at the time, date a	nd place, and due to the cause(s)
	withi To 11 comp	M	29b. Signature and title of certifier	29c. License number	29d. C	ate signed (Month, Day, Year)
}			M CM	1060/08	4/	5/06
	10		30. Name and address of person who completed cause of death (Item 23a) (Type Muhamman To Bhadar 28) E. Ma  31. Date filed (Month, Day, Year)  APR 1 0 2006	Print) CL RCLAS	u nen	21911
	1		31. Date filed (Month, Day, Year)  22. Registrar's Signature	or Illand or	un , / · · · · ·	
	Sta Registr		APR 1 0 2006			
		***				

ician dical	,	. Decedent's Name (First, Middle,	Last)						:	2. Date of Dea	ath Day	Year		Death AM
	1	a. Facility Name (If not institution,	hive street and no	avan		4b. City.	Town, or Loc	ation of	Death	3	4c. Co	Unty of De		0
niner		Bradford Oaks Nurs		imbory		Clin							orge's	
al or	_1	Social Security Number	5. Sex 1 □ M 2 □ F	7. Age (In yrs.	last birthday) Yrs.	If Under Months		Under 2 ours	4 Hrs. Min.	8. Date of Birt (Month, Da 10/22/28	y, Year)		irthplace (State Country) Jersey	or Foreign
once.  To Be Completed by Funeral Director	-	Sual Residence of Decedent  0a. State 10b. County		10c. Ci	ty, Town or Le	ocation							10d. Inside C	ity Limits
ţo	1	Maryland Prince	<del>le</del> orge	Bra	andywine	9							1 🗆 Yes	2 🕅 No
lrec	1	10e. Street and Number				10f. Zip Code					10g. Citizen of What Country?  USA			
ral		11724 Crestwood Ave. North				20613								
by Funeral Director	1	11. Marital Status  1 Never Married 2 Married  3 Wildowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes 2 No If Yes, Give Year or Dates:			J.S. 13.	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 □ Yes 2 ☆ No Specify:					Black, White, etc.  Specify: White			
ted		15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Gi				edent's Usual Occupation e kind of work done during most of working					16b. Kind of Business/Industry			
Completed	-	Elementary/Secondary (0-12) 12th	nentary/Secondary (0-12) College (1-4or 5+)			Homemaker					At Home			
To Be C		17. Father's Name (First, Middle, Last)  John Aloysius Dempsey					1	Maria	ah N	(First, Middle, Yilady				
		19a. Informant's Name/Relationsh					s (Street and I						, Zip Code)	
		Joanann Monahan Wal	ther/Daugh	20b.	Place of Disp	osition (Na.	twood Av	e. N		ate			or Town, State	
	-	1 ☐ Burial 2 🎇 Cremation	3 □Removal from	State	cemetery, cre las Cre	matory or o	other place)	    ML-	mah ?	6, 2006	Edgewa			
	-	* 4 □ Donation 5 □ Other (Sp 21. Signature of Funeral Service L		/ 1.00			nd Address of							
		I Son f.	Kalas	·h 1			on Hill							
		23a. Part 1. Filer the disease, or shock, or heart failure. List of	mplications that	caused the dea	ith. Do not en	ter the mo	de of dying, su	uch as	cardiac or	respiratory a	rrest,		Approxima Interval Be	tween
		Immediate Cause (Final disease or condition	CH	Rmic	OBS	Truc	Time	Pu	Ju.		O, sa	90	Onset and	Deam
		resulting in death)	dDun te	1.00			~ ' • • '	4 -		MA	0,400	-		
			Dust	(or as a conse		,	2(10)			717	0.400	-(		
4		Sequentially list conditions,	b. ———		quence of):		2(10)			7	0.400			
miner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. ———	o (or as a conse	quence of):	-	2.01			<i>m</i> ¬				
Examiner		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to		quence of):					<i>/</i> m¬				-
ical		Cause, Enter Underlying Cause (Disease or injury that initiated events	b. Due to	o (or as a conse	quence of):					<i></i>				
ical		Cause, Enter Underlying Cause (Disease or injury that initiated events	b. — Due to	o (or as a conse	quence of): quence of): quence of):					<i>/</i> //				
ical		cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	o (or as a consection of oregraphical time of pregraphical time of oregraphical time or or or or or or or or or or or or or	quence of):  quence of):  quence of):  annoy tal death 3	□Ectopic p	pregnancy			<i>/</i> //		d. Date of c	delivery Day	Year
Physician/Medical		cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ► No	b. Due to c. Due to d.  23c. If yes, o 1   Live 4   Pres	o (or as a consecutcome of pregruth 2 Fet grant at time of mown	quence of):  quence of):  quence of):  anncy tal death 3 death 5	□Ectopic p □ Other (s	oregnancy pecify)			23a. Did 1	236	d. Date of c Month	Day a to the cause of	death?
by Physician/Medical		Cause, Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	b. Due to c. Due to d.  23c. If yes, o 1   Live 4   Pres	o (or as a consecutcome of pregruth 2 Fet grant at time of mown	quence of):  quence of):  quence of):  anncy tal death 3 death 5	□Ectopic p □ Other (s	oregnancy pecify)			23a. Did 1	230	d. Date of c Month	Day	death?
ompleted by Physician/Medical		Cause, Enter Underlying Cause, (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	b. Due to c. Due to d.  23c. If yes, o 1   Live 4   Pres	o (or as a consecutcome of pregruth 2 Fet grant at time of mown	quence of):  quence of):  quence of):  anncy tal death 3 death 5	□Ectopic p □ Other (s	oregnancy pecify)			23e. Did 1	23d tobacco use Yes 2□	d. Date of o	Day  a to the cause of  Probably 4   autopsy findings to completion of	death?  Unknown s available
Completed by Physician/Medical		Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to c. Due to d.  23c. If yes, o 4 Pres 9 Unk ns contributing to	o (or as a consecutcome of pregruth 2 Fet grant at time of mown	quence of):  quence of):  quence of):  anncy tal death 3 death 5	□Ectopic p □ Other (s	oregnancy pecify) cause given in	n Part I.		23e. Did 1	tobacco use Yes 2  an psy psy psy 2 No	d. Date of o	Day  a to the cause of  Probably 4   autopsy finding to completion of	death?  Unknown s available
To Be Completed by Physician/Medical		Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant condition	b. Due to c. Due to d.  23c. If yes, o 1 \( \) Live 4 \( \) Prey 9 \( \) Unk ns contributing to	o (or as a consecutcome of pregrebirth 2 Fet grant at time of nown death but not re	quence of):  quence of):  quence of):  ancy tal death 3 death 5  usulting in the	□Ectopic p □ Other (s underlying	oregnancy pecify) cause given in	n Part I. 3. Place	of Death	23e. Did I  1  24a. Was 24a. was 24a. Yas (Check only ne 5  Res	tobacco use Yes 2	d. Date of commonth  contribute  No 3   24b. Were prior 1 death 1  Y	Day  a to the cause of  Probably 4   autopsy finding to completion of ??	death?  Unknown s available
To Be Completed by Physician/Medical		Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to c. Due to d.  23c. If yes, o 1 Live 4 Pres 9 Unk ns contributing to  Hospital: 1 Live 28a. Dat	o (or as a consecution of or as a consecution of pregration of pregramment of pregramment at time of nown death but not respectively.)	quence of):  quence of):  quence of):  nancy tal death 3 death 5 death 5 death 5	□Ectopic p □ Other (s) underlying	oregnancy pecify) cause given in	n Part I. 3. Place	of Death	23e. Did I	tobacco use Yes 2	d. Date of commonth  contribute  No 3   24b. Were prior 1 death 1  Y	Day  a to the cause of  Probably 4   autopsy finding to completion of ??	death?  Unknown s available
To Be Completed by Physician/Medical		Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to c. Due to d.  23c. If yes, o 1 Live 4 Pre, 9 Unk ns contributing to  Hospital: (Mo	o (or as a consecutcome of pregrebirth 2 Fet grant at time of nown death but not re	quence of):  quence of):  quence of):  quence of):  ancy tal death 3 death 5 death 5 death 5 less time  ER/Outpatie  28b. Time Injury	□Ectopic p □ Other (s) underlying  ent 3□ D of M	cause given in  26 OA Other: 28c. Injury at Work? 1 □ Yes	n Part I. 3. Place	of Death rsing Hon 2 No	23e. Did I  1 24a. Was 24a. Was 24f. Yes (Check only ne 5   Resi 28d. Describe	tobacco use Yes 2 in an psy ormed? 22 No one) idence 6 [ how injury of	d. Date of c Month  contribute  No 3   24b. Were prior t death 1  Y	Day  a to the cause of  Probably 4   autopsy finding to completion of ??	death? ]Unknown s available cause of
Certification: To Be Completed by Physician/Medical Examiner		Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to c. Due to d.  23c. If yes, o 1 Live 4 Pres 9 Unk ns contributing to  Hospital: 1 Cation ation oot be ned 28e. Pla buil g Physician: To the	utcome of pregression of cor as a consecution of pregression of pregression of the correction of the c	quence of):  quence of):  quence of):  quence of):  quence of):  ancy tal death 3 death 5 death 5 death 5  ER/Outpatite 28b. Time Injury  home, farm, s injury	□Ectopic p □ Other (s underlying  ent 3□ D of M treet, facto	cause given in  26 OA Other: 28c. Injury at Work? 1 \( \text{Yes} \)	n Part I.  3. Place 4)  2 □ I	of Death rsing Hon 2 No 2	23e. Did to the sauto perficience of the sauto perficience of the sauto perficience of the sauto perficience of the sauto perficience of the sauto performance of the sauto	tobacco use  Yes 2  an psy one) idence 6 [ how injury of win, State)  cause(s) ar	d. Date of o Month  contribute  No 3   24b. Were prior 1 death 1   Y  Other (S) pocurred	Day  a to the cause of Probably 4  autopsy finding to completion of ??  (es 2 No  (pecify)  Rural Route Nu	death? [Unknown s available cause of
To Be Completed by Physician/Medical Examiner		Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to c. Due to d.  23c. If yes, o 1 Live 4 Pres 9 Unk ns contributing to  Hospital: 1 Cation ation oot be ned 28e. Pla buil g Physician: To the	utcome of pregression of core as a consecution of pregression of pregression of the core o	quence of):  quenc	□Ectopic p □ Other (s underlying  ent 3□ D of M treet, factor	cause given in  26  OA Other: 28c. Injury at Work? 1 \( \triangle	n Part I.  3. Place 4.1  date an on, dea umber	o of Death rrsing Hon 2 No 2 d place, a	23e. Did to the ad at the time,	tobacco use  Yes 2  an psy psy pomed? 2 No one) idence 6 [ how injury of wn, State)  cause(s) an date and p  29d. Date	d. Date of o Month  contribute  No 3   24b. Were prior t death 1  Y  Other (S)  occurred	Day  a to the cause of Probably 4  autopsy finding to completion of ?  es 2 No  Pecify)  Rural Route Number of the cause onth, Day, Year)	death? [Unknown s available cause of
edical Certification: To Be Completed by Physician/Medical		Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	b. Due to c. Due to d.  23c. If yes, o 1 Live 4 Pres 9 Unk ns contributing to  Hospital: 1 Cation ation oot be ned 28e. Pla buil g Physician: To the	utcome of pregression of core as a consecution of pregression of pregression of the core o	quence of):  quenc	□Ectopic p □ Other (s underlying  ent 3□ D of M treet, factor	cause given in  26  OA Other: 28c. Injury at Work? 1 \( \triangle	n Part I.  3. Place 4.1  date an on, dea umber	o of Death rrsing Hon 2 No 2 d place, a	23e. Did to the ad at the time,	tobacco use  Yes 2  an psy psy pomed? 2 No one) idence 6 [ how injury of wn, State)  cause(s) an date and p  29d. Date	d. Date of o Month  contribute  No 3   24b. Were prior t death 1  Y  Other (S)  occurred	Day  a to the cause of Probably 4  autopsy finding to completion of ? es 2 No  specify)  Rural Route Nu as stated, due to the cause	death? [Unknown s available cause of

		1 - For State Registrar	State of Marylar			nt of Hea te of De			jiene eg. No.	To a state of	113	25
		1. Decedent's Name (First, Middle, Last)						2. Date of Dea Month	th Day	Year	3. Time o	of Death
Physici /Medio		Annie Mae N	loses					March	17	2006	21	45 M
Examir		4a. Facility Name (If not institution, give s			4b. City		ocation of Death		4c. C	County of Death		
			orge's Hospit		1611		Chever1: f Under 24 Hrs.			Prince		
Funeral Director		379-30-0733	M OKIE	2 Yrs.	Months		Hours Min.	8. Date of Birth (Month, Day Jan. 2,	, Year)	4 Nort	place (State ntry) h Care	or Foreign
/land		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation						10d. Inside (	City Limits
within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show the Medical Examinational Le notified at	ctor	DC					Washin	gton			1 🛣 Ye	s 2 No
with the	Funeral Director	10e. Street and Number	-+1- A N E	#2	10f. Zi	p Code	20019	1	-	en of What Cou		
18 23	eral	1537 Kenilwon	12. Was Decedent Ever in U		Was Dece	dent of Hispa		pecify Yes or No-		nited S		
r, or Item	by Fun	1 □XNever Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:			2 XNo		pecify Yes or No- p Rican, etc.)		Black, White,		
Department of Health and Mental Hygiene. Importent: if them 27 is marked other then "neturel", or Items 23e or 28e-f show any injury or other treumatic event. The Madical Examinational be notified at ODGE.	Completed t	15. Decedent's Edu (Specify only highest grade	cation co <i>mpleted)</i>	16a. Dece (Give	dent's Usu kind of w	ial Occupations done duri	on ing most of work	king	16b. Kin	d of Business/In	dustry	
then.	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)				ive Ass			Priva	te	
Hygi Sther ent.		17. Father's Name (First, Middle, Last)		l A	.umzii.			ne (First, Middle,	Maiden S			
ked c	To Be	Benjamin F	Moses					Bettie	L. W	ynn		
s mar umat	-	19a. Informant's Name/Relationship (Type		19b. Maili	ng Addres	s (Street and	d Number or Ru	ral Route Number	r, City or	Town, State, Zip	Code)	
alth alth 127 is		Debra Bond/Daught	er	11005	Fath	er Th		ail, Upp	er M	ar1boro	, MD 2	20772
r oth		20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R		Place of Dispo cemetery, cre	osition (Na matory or	me of other place)		Date	20c. Loc	ation - City or To	own, State	
ant: fi		`4 □ Donation 5 □ Other (Specify)	Li	ncoln	Memor	ial C	em. 3/2.	5/2006	S	uitland	, MD	
Departr Import any inj		21. Signature of Funeral Service License	e A TT	2	2. Name a	nd Address		Stewart Rd., N.				10
101 00		23a. Part). Enter the disease, or compli	cations that caused the dea	th. Do not en	ter the mo					asii., D	Approxima Interval Be	
hysician		shock, or heart failure. List only or Immediate Cause (Final disease or condition	Acute cer								Onset and	etween d Death days
/Medical Examiner		resulting in death)	Due to (or as a consec Cardiac a		e						14	days
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec									
ysician and	Ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Hypertens  Due to (or as a consec		art d	liseas	e				10	years
itte has been signed by the attending phy tage 2 should be detached for use as thi	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn	al death 3[	⊒Ectopic r				23	3d. Date of deliv	ery Day	Year
nat me de led by the a detached f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of o	ieath St	Other (s	рөспу)						
igned b	by Pl	Part II. Other significant conditions cor	tributing to death but not re	sulting in the u	underlying	cause given	in Part I.	23e. Did to	bacco us	e contribute to t	he cause of	death?
been sig should b		Chronic re	enal_failure					1 🔀 Y	es 2	No 3 ☐ Prol	bably 4	]Unknown
ate has been page 2 shoul	ompleted				·			24a. Was a autop:	sv	24b. Were auto prior to co death? 1 \sum Yes	opsy finding empletion of	s available cause of
	O	25. Was case referred to medical				2	6. Place of Dea	1 ☐ Yes		10103	20,110	
d in	0 8	examiner? 1 Yes 2 No	lospital: 1 Kanatient 2	] ER/Outpatie	nt 3 D	OA Other:	4 ☐ Nursing H	ome 5 Resid	ence 6	Other (Special	fy)	
After fune	tion; T	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work?		28d. Describe h				
after death.  Director: A	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, st	reet, facto	ry, office		28f. Location (S City or Tow		Number or Run	al Route Nu	mber,
within 24 hours after de To the Funerel Direct	edical C	29a. Certifier (Check only one)  1 Certifying Physical Examination	sician: To the best of my kn ner: On the basis of examin and manner stated.	owledge, deal ation and/or in	th occurred nvestigatio	at the time, n, in my opin	date and place tion, death occu	, and due to the or rred at the time, o	ause(s) a late and p	and manner as s place, and due t	stated. o the cause	(s)
within To the	Me	29b. Signature and title of tertifier			29	c. License n	number	2	29d. Date	signed (Month,	Day, Year)	
		No all	rayus	•			D28195		M	arch 20	, 200	6
(2)		30. Name and address of person and co										
		David Goors	ay, M.D. 300	1 Hosp	<u>ita</u> l	Drive	. Cheve	rly, MD	207	85		
Sta Regist	ate	MAR 2 4 2006	Water A	A.	20							

State of Maryland / Department of Health and Mental Hygiene U U o State Registrar Amended 16b, 3/29/06, LDB, DOR Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year Fiona Patricia McD. MacDonald March 25 2006 2055 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Memorial Hospital Talbot Easton If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 74 Yrs. Director 223**-**74**-**5026 March 20, 1932 United Kingdom Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show or other traumatic event, the Medical Examiner must be notified at Maryland Dorchester 1 Nes 2 No Directo Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 804 Maryland Avenue 21613 iteme 23s United Kingdom Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 140 If Yes, Give Year or Dates: 1 Never Married 2 Marned ö 1 Yes 2 No Specify Specify: White Completed by 3 Widowed 4 Divorced "natural", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Investment/Financial and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Investment Broker Investment/Financ 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental H 2 Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28839 Jasper Lane, Easton, MD 21601-8306 Donald E. Stukey/PR 20a. Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Unk. 20c. Location - City or Town, State 4 □Donation 5 □ Other (Specify) Largs Cemetery Ayershire, Scotland Signature of Funer Service Licensee Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD 21613 Curran-Bromwell Funeral Hom 308 High St., Cambridge, MD Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** METASTATIC COLON CANCER /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit physician and Due to (or as a consequence of): Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 1 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ٥ 1 Inpatient 2 □ ER/Outpatient 3□ DOA this Director; After th 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Medical Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter To the Funeral Dire 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) olu Bretsus D0059487 26 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. John Botsis, 219 S. Washington St., Easton, MD 21601 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

Mac Donalo

AR 2 9 2006

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year Month Guy Thomas Mowbray March 23 2006 7:32 p 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dorchester General Hospital Cambridge Dorchester If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 MM 2□ F 218-24-5697 Sept. 10, 1928 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 □ No Dorchester Cambridge 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 513 Academy St. 21613 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XX es 2 □ No If Yes, Give Year or Dates: 1955-57 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 → No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) machinist chemical mfq. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Roland Mowbray Rena Barqman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) wife 513 Academy St., Cambridge, MD Lois Mowbray 21613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State ' 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cem. 3/27/06 Hurlock, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) respiratory Due to (or as a consequence of): Sepsis Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death

**Physician** /Medical Examiner

physician and s the burial-transit

nding p as

atten for u

been signed by the s should be detached

director,

After

within 24 hours after death To the Funeral Director: completely filled in by the

filled in by

death.

Hospitel or Attending Physicien: The law requires that the death certificate be executed

P.O. Box 68760.

Division of Vital Records,

Physician/Medical Examiner

Completed by

Be

٥

Certification;

Medical

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importaet: If item Z7 is marked oth any injury or other treumatic event size.

**Physician** 

/Medical

Examiner

10a. State

MD

Funeral

Director

items 23a or 28e-f show

2 should be filed within 72 hours after and Mental Hygiene. Is marked other then "naturel", or ite

Baltimore, Maryland 21215-0036

the Medical Examiner must be notified at

Director

Funeral

þ

Completed

Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☑ No

27. Manner of Death

1 SNatural

2 Accident

4 Homicide

3 Suicide

29a, Certifier

IF FEMALE

Dav Month 5 Other (specify)

1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. rdiovascular disease.

structive philmonesy

1 🕳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

23e. Did tobacco use contribute to the cause of death? 1 SYes 2 No 3 Probably 4 Unknown

autopsy performed? Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

2 No

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

5 Pending

investigation

6 Could not be

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Malkus, M.D 408 Byrn Street 31. Date filed (Month, distrar's Signature 8 2006

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** March 26, 2006 5:45A<sup>M</sup> Mildred Moskowitz /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Rockville Montgomery Hebrew Home If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Ye 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2X F Director 94 Dec 23, 1911 045-26-1165 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f ehow 1 XYes 2 No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 end 2 should be filed within 72 hours after death with Innet of Heelth and Mental Hygiene.
ant: If Item 27 is marked other then "neturel", or Itema 23e or 3 ury or other traumatic event, the Medical Examinar must be no 6105 Montrose Road #2105 20852 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: White 1 ☐ Yes 2 XNo Specify. à 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales 12 Salesperson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (unknown) Joseph Klein ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type, Print) 3210 N. Leisure World Blvd. #621 Silver Spring, MD Jack Moss/son Important: if item, any injury or other page. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Marche 28, 1 ☐ Burial 2 ☐Cremation 3 ☐Removal from State 2006 Chesapeake Crematory Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the obease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Pneumonia /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury Due to (or as a consequence of): Examiner physicien end s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical as the ettending I for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) signed by the e 1 ☐ Yes 2X No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by should be Hypertension, Breast Cancer, Dementia 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Rectovaginal Fistula s certificete hes t lirector, page 2 s autopsy performed: 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospitel or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4X Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ▼No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after der he Funara! Directo pletely filled in by th 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature March 28, 2006 nd address of person who completed cause of death (Item 23a) (Type, Print) Fris E. Kuhn, MD MI rose

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day,

Day, Year)

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

32. Pagistrar's Signature

			1 - For State Registrar	State of Maryla		artment of H			giene Reg. No.	)6	1132	9			
	Physic /Medi		1. Decedent's Name (First, Middle, La. William J. Nic	klaw				2. Date of De. Month March	24, 200		3. Time of De 3:10 P	ath M			
	Exami	ner	4a. Facility Name (If not institution, given Suburban Hospita  5. Social Security Number 6. S	1	. last birthday)	4b. City, Town, or  Bethese If Under 1 Year	Location of Death  a  If Under 24 Hrs.	8. Date of Birt	4c. County Montge	omery	ace (State or Fo				
	Funeral Director		074-18-6489 Usual Residence of Decedent	X) M 2□F   81	Yrs.	Months Days	Hours Min.	Mar II,	1925	New \	York	reign			
	ы Marylar Ba-f show	ector	MD 10a. State 10b. County Montgome		ity, Town or Lo						0d. Inside City L				
	ath with the	Funeral Director	10e. Street and Number 5943 Valerian La	1		10f. Zip Code 2085			10g. Citizen of V United		-				
9600	72 hours after death with the Maryland natural; or iteme 23e or 28e-f show dical Examinar mast be rediffed at	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Amed Forces? tyTlyes 2 □ No 194 if Yes, Give Year or Dates: 194	13. 43 <b>–</b> 46	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	spanic Origin? (Spanic Origin?) n, Maxican, Puerto Specify:	ecify Yes or No Rican, etc.)		e-America ck, White, e v: Whit	itc.				
Maryland 21215-0036	d within 72 h giene. or than "natu	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done o DO NOT use retired Ciation E	luring most of work! ) Xecutive	ļ	Americar Health-S	System					
yland	tould be file I Mental Hygnarked other natic event,	To Be C	17. Father's Name (First, Middle, Last) Francis A. Nick	Law			18. Mother's Name	e Mary	Gordon						
ore, Mar	s 1 and 2 sh of Health and Item 27 is m		19a. Informant's Name/Relationship (194) Feru Zappala / William Za	Lfe 20b.	5943	ng Address (Street a Valerian Street of the colors of the	Lane/ Nor			D 208	52				
Baltimore,	permit. Pages 1 and 2 should be tiled within 72 hours atter death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or iteme 23a or 28a-f show any intro or other traumatic event, the Medical Examination and page.		1 Burial 2 Removal from State 4 Donation 5 Other (Specify)  National Crematory  21. Signature of Funeral Service Licensee  1 Burial 2 Removal from State 4 Donation 5 Other (Specify)  National Crematory  22. Name and Address of Facility  3 Song  24. Name and Address of Facility  3 Song  5130 Wis. Ave. NW Washington, DC 2001												
	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and plants of the cause. Enter Underlying Cause (Disease or injury	b.  Due to for as a consector.	Fibros: qu <i>e</i> nce of):		j, such as cardiac c	or respiratory ar	rest,		Approximate Interval Betwee Onset and Deal	n h			
8760,	cate be executed ohysicien and the burial-transit	Ilcal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consected.	quence of):							_			
P.O. Box 6	The law requires that the death certificate be executed wie has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of o 9 □ Unknown	al death 3	]Ectopic pregnancy ] Other (specify)			23d. Dat Mol	e of deliver	y Day Y <i>e</i> ar				
	w requires that been signed b should be det	þ	Part II. Other significant conditions of	ontributing to death but not res	sulting in the u	nderlying cause give	n in Part I.	23 <i>e</i> . Did to	obacco use conti es ZNNo		cause of death				
of Vital Records,		Completed						24a. Was a autop perfor 1 🗀 Yes	sy p mead? c	leath?	sy findings avai pletion of cause	able of			
Vita	Physician: T r this certificet ral director, pa	Be	25. Was case referred to medical examiner?	Hospital:		100	26. Place of Death	(Check only or	ne)						
of	this aldir	2	1 Yes 2 No	1 yinpatient 2	ER/Outpatien		4   Nursing Hor								
Division	ding Afte fune	Certification;	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		28b. Time of Injury	Work M 1 □ Y	es 2 □No		ow injury occurr						
ρį	To the Hospital or Attending within 24 hours efter death.  To the Funers! Director: After completely filled in by the fune		4 Homicide determined  29a, Certifier % XCertifying Ph	building, etc. (Special	fy) 			City or Tow							
	24 hc 24 hc Fun etely	edical	(Check only 2 Medical Examone)	ysician: To the best of my kno niner: On the basis of examina and manner stated.	ation and/or in	estigation, in my op	e, date and place, a inion, death occurre	and due to the d ad at the time, o	ause(s) and ma late and place, a	nner as stated and due to t	ted. he cause(s)				
	To the within 2	Me	29b. Signature and title of certifier	i can, us		29c. License		2	29d. Date signed	/	ay, Year)				
	Sta	te	30. Name and address of person wood Asefa Jejaw Mekor 31. Date filed (Month, Day, Year)		n Lock		ll Rockví	11a, M			,				
	Pogiate	0.0	MAD 9 9 2		10 DO	BASS.									

DHMH 17 Rev 1/2001

NICKLAW, WILLIAMY 3/RYPOL @ 1510

	7	Registrar  1. Decedent's Name (First, Middle, L	ast)		Ce	rtificat	e or i	Jeaur		2. Date of Dea				3. Time of Death	
Physicia /Medic	- 9	Margaret L.	Ogle							Month MARCH	Day 20		ear	1434	
Examin		4a. Facility Name (If not institution, g	ive creet and nu	imber)		1		Location of	of Death			County of	Death		
· · · · · · · · · · · · · · · · · · ·		AAMC					napo		2111			Anne			
Funeral Director		212-22-8927	Sex 1 ☐ M 2 <b>XX</b>	7. Age (In yrs	last birthday; Yrs.	If Under Months		If Under Hours	Min.	8. Date of Birt (Month, Day Nov. 5,	h , Year) 191	9. Birthplace (State or Foreign Country) 14 Maryland			
3		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or L	ocation						10d. Inside City Lim			
r 28a-f show	Por	MD Anne A	runde1		Annapo								10	1 □ Yes 2√√X	
r 28a-	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of Wha	at Countr		
23a or	alD	5 Highland Aver	iue			2	1401					USA			
ema er Te	Iner	11. Marital Status		edent Ever in U	J.S. 13.			spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)		14. Race -	America White, et		
0.5	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes If Yes, Gi Year or I	ve		1 🗆 Yes		Specify:		,		Specify:		ite	
"natural" odical Ex	Completed	15. Decedent's (Specify only highest g		)	(Give	dent's Usua kind of wor	ok done o	lurina most	t of work	ing	16b. Kir	nd of Busin	ness/Indu	ıstry	
	du	Elementary/Secondary (0-12)	College (		life.	DO NOT us	se retired	)		9					
other than	Co	17. Father's Name (First, Middle, Las	:t)		ноте	maker		18 Mothe	ar's Name	e (First, Middle,		n Hor	ne		
it of Health and Mental Hyg If item 27 is marked othe or other traumatic event,	To Be	George Emmett E								Hodges	Maidell	Sumame)			
mark	ř	19a. Informant's Name/Relationship			19b. Maili	ng Address	(Street a			al Route Numbe	r. City or	Town, Sta	ate. Zip C	Code)	
Health a am 27 te		Virginia L. Wee	ms (Dau	ghter)						owhegan				•	
of Hea		20a. Method of Disposition	7.5		Place of Dispo	sition (Nan	ne of ther place	9)	Ē	Date	20c. Lo	cation - Cit	y or Tow	n, State	
nent a		1 ☐ Burial <b>XXX</b> Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		State	tro Cr			1	3-22	-2006	Balt	imore	a. M1	D	
Department o Important: If any injury or once.		21. Signature of Funeral Service Lice	eesne				_			Home, P			,		
D P e o		23a Part Enter the dil ease, or con				12 K	idge.	Ly Av	enue	, Annap	olis	, MD	2140	01	
ysician Medical aminer	ner	sho k, or heart farure. List onl Immedia e Cause (Firm disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury	a	ogestiv	quence of):	art	fai	lure						nterval Between Onset and Death	
nysicie he bur	edical Examiner	resulting in death) Last  Due to (or as a consequence of):  d.													
by the ettending ached for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 morfths? 1 □ Yes 2 PM 9 □ Unknown	1 Live t	tcome of pregn birth 2 Feta nant at time of a lown	al death 3[	Ectopic pro					2	3d. Date o Month	-	/ Jay Year	
signed by the e	by P	Part II. Other significant conditions	1 C'	eath but not res		nderlying ca	ause give	n in Part I.						cause of death?	
should l	eted	Nausea Vomi	nng T	2.47	rica					1 U Y	es 21	2 NO 3L	Probat	oly 4 Dunknow	
ate has	Completed by									24a. Was a autop perfor	sy	prio dea	r to comp	sy findings availab pletion of cause of	
otor, p		25. Was case referre medical						26. Place	of Death	Check only or		- ' -	165 2	L NO	
direc	10	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	Inpatient 2	R/Outpatier	at 3□ DO	A Othe	r: 4 🗍 Nur	rsing Hor	me 5 ☐ Resid	ence 6	Other (	Specify)		
r death. actor: After ti by the funera	atlon:	27. Manner of Death  1 Matural 5 ☐ Pending 2 ☐ Accident investigation		of Injury th, Day Year)	28b. Time o Injury	M 2	8c. Injury Work 1 🔲 Y	at ? ′es 2 □ N		28d. Describe h	ow injury	occurred			
within 24 nouts aried togarh.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	Certification:	3 Suicide 6 Could not determined		iome, farm, str fy)	eet, factory	, office			28f. Location (S City or Tow			or Aural I	Route Number,		
• Funera letely fille	Medical (	29a. Certifier 1 Certifying P (Check only one)	miner: On the b	e best of my kno asis of examina ner stated.	owledge, death ation and/or in	occurred a	at the tim in my op	e, date and inion, deat	d place, a	and due to the d ed at the time, o	ause(s) late and	and manne place, and	er as stat due to tl	ed. he cause(s)	
o th	Me	29b. Signature and title of certifier	, /				. License			2	9d. Date	signed (A	donth, Da	ay, Year)	
S - 0			Inl							Suite:	m	1		- 200/	
s = 0		rmun	MY				DO	66	271	2.5	111	arin	120	1,2006	

		1	State Amend Item	State of Ma 23a per D		id / Dep 856 <b>,0</b> 6				nd Me	ntal Hy	giene Reg. No	-	6	33
	ysicia Nedica	n	1. Decedent's Name (First, Middle, Last CLARA, MAR	Y, OLSOI	V						Date of D Month	. Da		Year 2006	3. Time of Death 4,31 AM
D. St.	amine		4a. Facility Name (If not institution, give UNION HOSPIT	AL			El	KTO				40	County	of Death	
Fund Direc	4		5. Social Security Number 6. Se 216 38 4422 10 Usual Residence of Decedent	X 7. Ag		last birthday)	If Undi Months	Days	If Under 2 Hours	Min.	Date of Bi (Month, D		1	Count	* '
Maryland	lie d at		10a. State 10b. County Maryland Cecil			th Eas		•						10	Od. Inside City Limits
h with the	at be not	Funeral Director	10e. Street and Number 107 Howard Street				10f. Z 219	p Code 01		-		10g. Citizen of What Country? United States			•
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show	EXAMINATION	2	11. Marital Status  1 □ Never Married 2 □ Married  3 ☆ Widowed 4 □ Divorced	12. Was Decedent! Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Was Dec If Yes, sp 1 ☐ Yes	ecify Cuba	spanic Origi n, Mexican, Specify:	in? (Specif Puerto Ric	y Yes or N can, etc.)	or No- 14. Race - American Indian, Black, White, etc.  Specify: White			
21215-0036 ad within 72 hours af gjene. er then "natural", or	The Madical	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0·12) 12	cation e <i>completed)</i> College (1-4or 5	+)		kind of w DO NOT	ork done d use retired	<i>luring</i> most ( )	of working			ind of Bu	usiness/ind	lustry
Maryland 2 nd 2 should be filed lith and Mental Hygic 27 Is marked other	hatic event	lo Be C	17. Father's Name (First, Middle, Last) Edward Martell						18. Mother	а М. (	(unkno	own)			
Mar ind 2 sh alth and 27 is m	ar traum		19a. Informant's Name/Relationship (T) Donna O. Hanna/dau				-		and Number l Rd.,						Code)
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If Item 27	ury or oth	72	20a. Method of Disposition  YE Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)			Place of Disponential Disponent	natory`or :e Co		:ion <sup>Ma</sup>	Date arch 2 2006				City or Tov Mary	
Dermit. Depart	any Inj		21. Signature of Funerat Service Licens			12	7 So	uth N	s of Facility	Street	, Nor	th E			21901
Physic /Medi			23a. Part1, Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a ACUTE  Due to (or as	ie. E R	RENAL	-	de of dyin		cardiac or re	espiratory a	arrest,			Approximate Interval Between Onset and Death
S, P.O. BOX 68/60, set that the death certificate be executed greed by the attending physicien and		Ical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as Due to (or as di	stron a conseq	n Macro	oglol	oulin	enia						
the death certificative the ettending ph	ched for use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	I3c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 🗌 Feta	Ideath 3□	Ectopic   Other (s	pregnancy					23d. Dat Moi	e of deliver	ry Day Year
The law requires that the ste has been signed by the			Part II. Other significant conditions co	ntributing to death be	ut not res	ulting in the u	nderlying	cause give	en in Part I.			tobacco i		ribute to the	e cause of death?
	page 2 sh	Completed											F		osy findings available inpletion of cause of
_ > 50 1	funeral director	0	25. Was case referred to medical examiner?  1  Yes 2 No  27. Mann of Death 1  Natural 5 Pending 2  Accident investigation	dospital: 1 Pinpatie 28a. Date of Injur (Month, Day	v	ER/Outpatier 28b. Time of Injury		28c. Injury Work	at A □ Nurs			idence			)
UIVISION OI the Hospital or Attending Phy ithin 24 hours after death.	ed in by the	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injubuilding, etc	ry - At ho (Specif	ome, farm, str y)					Location ( City or To			er or Rural	Route Number,
the Hospital or in 24 hours afte the Funeral Dir	etely fille	edical	29a. Certifier 1 ☐ Certifying Phy. (Check only one)	sician: To the best of	examina	wledge, deati	occurre vestigatio	at the time, in my of	e, date and pinion, death	place, and	due to the	cause(s , date and	and ma I place, a	nner as sta and due to	ated. the cause(s)
o the ithin 2 o the	ф		29b. Signature and title of entitier		MD	)		D O	number 0 63L	186				(Month, E	2006
3			30. Name and address of person who or	ompleted cause of de				on, M	arylar	nd 21	921				
Reg	State gistra	<b>.</b>	31. Date filed (Month, Day, Year) MAR 2 9 2006	32. Registra	r's Signa	coele	,								

Clara Mary Olson

DHMH 17 Rev 1/2001

Registrar

Amend Item 20b per FH, 6855,05/08/06hb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** RAYMOND 22,2006 8:03P /Medical DOUGLAS PRATHER SR March 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**X** M 2□ F Yrs Director 219-86-6407 May 21,1948 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehow must be notified at 1 Yes 2 No Director MD Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Itame 23a 7909 Badenlock Way #104 20877 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status o filed within 72 hours after di I Hygiene. other then "naturel", or Item the Medical Examiner 1 ☐ Yes XXNo 1 Never Married 2 Married Baitimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ۵ lf Yes, Givo Year or Dates: Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) State Road permit. Peges 1 and 2 should be filed will Depertment of Health and Mental Hygiene Important: If item 27 is marked other that any fillury or other traumatic event, the one. 12th Laborer Commission 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Maurice ပ Prather Eleanor Gibson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20877 19a. Informant's Name/Relationship (Type, Print) Iris M. Prather- Wife 7909 Badenlock Way #104 Gaithersburg, MD Encerne of Unisposition (Name of Encerne of Control of United Methodist Church Cenetery Grove United Methodist Church Cenetery Mr. 3/30/06 Silver Spring Mr. 22. Name and Address of Falls 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, PA Signature of Funeral Service License 246 N. Washington St Rockville, MD20850 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician COAGULOPATHY /Medical Due to (or as a consequence of) **Examiner** SEVERE SEPSIS Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760. physicien Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ö in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Sickle Cell Disease 1 ☐ Yes 21 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No Hemolytic hes page 2 1 ☐ Yes <u> Acute Pancreatitis</u> 2**X** No director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ⊠Inpatient 2 □ ER/Outpatient 3 □ DOA 2 1 Yes 2X No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After tnjury 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of trijury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours aft To the Funeral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ţ 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) ပ္ DR 63570 23/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maria Tauag 1500 Forest Glen Rd Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 28

LOBALL)

			For State Registrar	State of Ma	•	epartmei C <i>ertifica</i>			Mental H	ygieņe Reg. No.	006	11334
			1. Decedent's Name (First, Middle, Last	)					2. Date of D	eath Day	Year	3. Time of Death
	Physici /Medio		Barbara	Lee	Prokop				March		, 2006	12:05 P.M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City	Town, o	Location of Dea	th	4c. (	County of Deat	h
			Shady Grove Adven	tist Hosp:	ital			ille		M	ontgome	ery
	Funeral		Social Security Number     6. Se	x 7. Age ⊒M 2 <b>⊠</b> F	(In yrs. last birth	Months	r 1 Year Days	If Under 24 Hrs Hours Min		irth Day, Year)	9. Birt Co	hplace (State or Foreign
	Director		1/8-32-489/	J.W. 2631	63 Yr	S.			Feb. 1	8, 19	43	PA
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	daryl f ehc	ō	Manusland Montagn	0.7877	Potor	ma.a						1 ☐ Yes 2 🛣 No
	death with the Maryland me 23a or 28a-f ehow rmat be notified at	Director	Maryland Montgom  10e. Street and Number	ery	1000		Code			10g. Citiz	en of What Co	ountry?
	with Ba or	<u> </u>	12620 Onehand Bros	. Tamma a a			20854	<i>i</i> .		IIn-	ited St	ataa
	ne 2:	Funeral	12629 Orchard Broc	12. Was Decedent 8		13. Was Dece	dent of H	ispanic Origin? (5	Specify Yes or N	_	4. Race - Ame	nican Indian,
30	or ite	by Fur	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 K N If Yes, Give Year or Dates:	lo	If Yes, sp		Specity:	to Rican, etc.)		Black, Whit	e, etc. nite
215-0036	nature!,		15. Decedent's Edu	rcation	16a. D	ecedent's Usi	al Occup	ation		16b. Kin	nd of Business/	
3	within 72 ene. then "nai	Completed	(Specify only highest grad Elementary/Secondary (0-12)			Give kind of w life. DO NOT I	ork done i se retired	during most of wo	rking			·
7	7 7 1	E	Elementary/Secondary (0-12)	2		gistere	d Nu	rse		N	ursing	
<u> </u>	il Hygid other	Bec	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middl	le, Maiden S	Sumame)	
Vian	tould be Mental varked o	ToE	Rupert	Lux					Isabe	11e	Richa	ardson
Mary	2 should and Men is marke eumatic	,	19a. Informant's Name/Relationship (T)	rpe, Print)	19b. N	Mailing Addres	(Street	and Number or A	urai Route Num	ber, City or	Town, State, 2	Zip Code)
	s 1 and 2 should f Heelth and Mer item 27 is marks other treumatic		George Frank Proko	p/Husband	1262	29 Orch	ard	Brook Te	rrace,	Potom	ac, Ma	ryland 20854
ē.	of He of Herr		20a. Method of Disposition		20b. Place of D	Disposition (Na crematory or	me of other place	:0)	Date	20c. Loc	cation - City or	Town, State
Ĕ	Pages nent of int: if it	,	1 ፟ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		All Sou		•	· 1	0/2006	Geri	nantown	, Maryland
Baltimore,	permit. Pages Depertment of Important: If it eny injury or c	man program	21-Signature of Funeral Service License	1 lul	Van	102		ss of Facility D		neral	Home	MD. 20877
			23a. Part1. Enter the disease, or comp	lications that caused	the death. Do no						sburg,	Approximate
	Dhusisian		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each lin		. /	1 4 1	r cai	1000			Interval Between Onset and Death
	Physician /Medical	. 0	disease or condition resulting in death)	a. Due to for an				G CAI	VCIER	-		4 MONTHS
	Examiner			Due to (or as	a consequence of	):						
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of	):						
	nsit	m in	cause. Enter Underlying Cause (Disease or injury									
	execu n and al-tra	Examin	that initiated events resulting in death) Last	Due to (or as	a consequence of	):						
04/8	cate be executed physicien and the burial-transit	dical		d								
8		edic										
X Q Q	law requires that the death certifines been signed by the attending I 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		200				2	3d. Date of de	ivery
	death e atte	Cla	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at	2 Fetal death time of death	3 □Ectopic p 5 □ Other (s		·			Month	Day Year
j.	t the by the ache	hys	9 Unknown	9□ Unknown					,			
", J	signed to det	by P	Part II. Other significant conditions co	ntributing to death be	ut not resulting in t	he underlying	cause giv	en in Part I.	23e. Dio	l tobacco us	se contribute to	the cause of death?
ĕ	w require been sig should b	pe F							1	Yes 2.E	3No 3□Pr	obably 4 Unknown
Vital Records	s been shoul	Completed							24a. We		24b. Were au	topsy findings available
Ë	o - 2	E C							per	opsy formed?	death?	completion of cause of
œ	ilcien: Th certificete rector, peg	Ö	25. Was case referred to medical					26 Place of De	1 ☐ Yes ath (Check only	-	1 L Yes	20 No
		0 3	examiner?	Hospital: Inpatie	nt 2□ER/Outp	atient 3 🗆 0	Oth Oth	0.0	Home 5 ☐ Re		□Other (Soe	cifu)
Ö	y Phys er this eral di	Ë	27. Manner of Death	28a. Date of Injur	y 28b. Tin	ne of	28c. Injur	y at	28d. Describe			ony)
DIVISION	r Attending Pier death. Irector: After i by the funera	at lo	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	<i>r Year)</i> Inji	ury M	Wor 1 □	k? Yes 2∐No				
<u>s</u>	Attendi r death. octor: A by the fu	100	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inju	ury - At home, farm c. (Specify)	n, street, facto	y, office					ural Route Number,
É	afte Dire	Certification;	4 Homicide	building, etc	с. (Бресіту)				City or I	own, State)		
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one) Certifying Phy	sician: To the best of	examination and/	death occurre	at the tir	ne, date and plac pinion, death occ	e, and due to th urred at the time	e cause(s) a	and manner as place, and due	s stated. e to the cause(s)
	ithin (	Med	29h Signature and title of certifier	and manner sta		2	c. Licens	e number		29d, Date	signed (Mont	h, Day, Year)
	8 1 ₹ 1	1	Aller	P P I	(10		Λ,	46187		MAD	1/ 1/ 9	4 222/
			/VVV X	2 (1 1 - 16		uus)	<u> </u>	40107		1-171,2	SCH of	1,2006.
	20		30. Name and address of person who co	ompleted cause of d	eath (Item 23a) (T	ype, Print)	. , , , , ,	6 Pive	2 4/02	p k	POCKVII	4, 2006. LE, MD 2085
			31. Date filed (Month, Day, Year)	32. Ranietra	ar's Signature	NUCK	VILL	x 1120	THE	7 /	.000	2001
	Sta Registr		MAD 9 2 7	nns A	and M.	Societie	8					
			I O & Arim	300								

			For State Registrar	State of Marylan	-			lealth ar Death		F	Reg. No.	06	113	35	
	Physici	an	1. Decedent's Name (First, Middle, Last, John G. Pupjak, Jr							2. Date of Dea Month March	23.	, 2ÖÖ6		of Death	
	/Medic Examin		4a. Facility Name (If not institution, give Laurel Regional Ho	street and number)			, Town, or aure	Location of		iarcii	4c. 0	County of Dea Prince	th		
***	Funeral Director			7. Age (In yrs. 82		If Unde Months	Days	If Under 24 Hours	4 Hrs. 8	B. Date of Birt (Month, Day Aug • 24	, Year) , 192.	9. Bir Co Inc	thplace (State puntry) liana	or Foreign	
	Maryland a-f show	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland  Prince Ge		y, Town or Lo			_			10d. Inside City Limits 1   Yes 2 X No				
	3a or 28	al Direc	10e. Street and Number 10405A 46th Avenue	e, #201		10f. Z	ip Co <b>de</b>	2070	)5		10g. Citizen of What Country? United States				
036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "naturel", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Maritat Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII	-	Was Dec If Yes, sp		ispanic Origi In, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No- ican, etc.)	No-  14. Race - American Indian, Black, White, etc.  Specify: White				
21215-0036	within 72 ho ene. than "natur the Medical	Completed	15. Decedent's Ed. (Specify only highest grad	cation le completed) College (1-4or 5+)	16a. Dece (Give life. Conti	kind of w DO NOT	rork done i use retired	during most o	of working	g		of Business  Navy	/Industry		
Maryland 2	Mental Hygie Mental Hygie arked other atic event,	To Be Co	17. Father's Name (First, Middle, Last) John G. Pupjak, St	·				Kathe	erine	(First, Middle, Koska	1				
	1 and 2 shoul Health and Mi iem 27 is mari		19a. Informant's Name/Relationship (T) Michael Pupjak -so			-				rtonsvi				866	
ore,	or othe		20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ F	nemoval from State	Place of Disponentery, cre				Da /20/2	1,1		cation - City or			
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		4 □ Donation 5 □ Other (Specify, 21. Signature of Funeral Service Licens		on Cer	2. Name	nd Addre	ss of Facility Borgwa	28/2 irdt Roa	Funera d Belt	1 Hor	onsvil me,P.A le. Mai			
445	· · · · · · · · · · · · · · · · · · ·		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o		h. Do not en	iter the m	ode of dyin	ng, such as c	cardiac or	respiratory ar	rrest,	,	Approxim Interval E Onset ar	nate Between	
	Physician /Medical Examiner	Examiner	disease or condition resulting in death)  Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Metastatic  Due to (or as a conseq b. Cua to (or as a consex) c.	uence of):	Canc	er								
3760,	cate be executed physician and i the burial-transit	cai	resulting in death) Last	Due to (or as a conseq	uence of):										
.O. Box 68	death certiff e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	it death 3	□Ectopic □ Other (	pregnancy specify) _	/			2	3d. Date of de Month	alivery Day	Year	
s, P	uires that I signed by Id be deta	by	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	underlying	cause giv	ren in Part I.				se contribute		of death?	
Record	The law requires that the set has been signed by the page 2 should be detache	Completed								24a. Was autor perio					
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital: VPX			Ott	ler.		(Check only o					
of	Phys this ral dii	1: To	1 ☐ Yes 2 ☒ No  27. Manner of Death	28a. Date of Injury	ER/Outpatie		28c. Injui Woi	4 🗆 INUI:		ne 5 Resi			ecity)		
Division	or Attending after death. Director: After in by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day Year)  28e. Place of Injury - At h building, etc. (Speci	ome, farm, si	M treet, fact	1 🗀	rk?  Yes 2 □ N		8f. Location (			Rural Route N	lumber,	
۵	To the Hospital or A within 24 hours after To the Funeral Director Completely filled in by		29a. Certifier (Check only 2 Medical Exam	/sician: To the best of my kno iner: On the basis of examina	owledge, dea	ith occurre	ed at the til	me, date and opinion, deati	d place, a	nd due to the	cause(s) date and	and manner a	as stated. se to the caus	se(s)	
)	To the To the complet	Medical	29b. Signature and title of certifier	and manner stated.		2		53987				e signed (Mor	-	r)	
			30. Name and address of person who of Kenneth Ngu Achir	completed cause of death (Iter	m 23a) (Type 00 A <b>r</b> m	ory l	Place	, Suit	te34	Baltim	ore,	Maryl	and212	01	
·	St. Regist	ate	31. Date filed (Month, Day, Year) MAR 2 8 20	32 Registrar's Sign	ature do	sell)									

Please Type of Print in Black indelible link
State of Maryland / Department of Health and Mental Hygier
Certificate of Death

Reg. No.

1- For State
Registrar
Decedent's Name (First, Middle,Last)
Eric Jan Paulson
4a Facility Name (if not institution, give
Carroll Hospital Center

_	To the Hospit within 24 hour
	12

Phyšícia al Exami		Decedent's Name (First, Middle,L	.ast)						1	2. Date of Dea Month	Day Year		me of Death		
ai Laaiiii	ner	Eric Jan Pauls 4a Facility Name (if not institution,			4	b. City, Town	or Lo	cation of E	Death	April 3, 20	4c. County of		O-77 (10)		
	.	Carroll Hospital Center				Westmin	ster				Carroll				
Funeral		5. Social Security Number 6.	Sex 7. Age (In	yrs. last birt	hday)	If Under 1 \		If Under 2	24Hrs. Min		th (MM/DD/YYYY)	9 Birthplace Country)	e (State or Forei		
Director		Usual Residence of Decedent	M 2 F	34			Jays	riours	IVIII	May 2	21 1971		CO		
ow any		10a. State 10b. County		. City, Town									Inside City Limit Yes 2 V		
a-f sh	ctor	MD Ca. 10e. Street and Number	rroll	F'1	nksb	urg 10f. Zip Cod				1	Oa Citizen of Wha	g. Citizen of What Country?			
or 28	Director	2005 Old Westm	inster Pike				21048 USA								
should be three winn 1.2 nous aret usen with the Manyand and Mental Hygene 7 is marked other than "natural", or items 23a or 28a-f show intic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Married 2 Married	1 Yes 2 X			Decedent of s, specify Cu				cify Yes or No tican, etc.)	14. Race - White,				
raf",	ρ		or Dates:			Yes 2 X					Specify:	Whi			
hii / 4 mour. han "natu dical Exan	Completed	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or 5+)	during	most of w	's Usual Occu orking life. D <b>signer</b>	O NOT	,		ork done	Interne Ad Agen	t	У		
tal Hygiene ked other t nt, the Me	Be Com	17. Father's Name (First, Middle, La	<i>'</i>	110		<u> </u>			,	First, Middle, I	Maiden Surname)				
th and Men 27 is marl umatic eve		19a. Informant's Name/Relationship Catherine Paulso						mins	ter	Pike	mber, City or Town Finksbur	g, MD	21048		
point. 1 1982   alia 2 should out the white frame and a linguistic of their and Mental Hygiene Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner m		20a. Method of Disposition  1 Burial 2 Temation  4 Donation 5 Other Spec	3 Removal from State	cremate	ory or oth	tion (Name of er place) remati			04/0	0872006	5 20c. Location - 0 Hamps	city or Town,			
Departm Departm Importa injury o		21. Signature of Funeral Service Lic	censee								Chapel, F		21157		
sician ledical		27a. Part I Enter the disease, or confailure. List only one cause on	each line.								est, shock, or hear	t App	proximate Inter- tween Onset and Death		
aminer		Immediate Cause (Final disease or condition resulting in death)	a. Mixed Drug (B. Due to (or as a consequer		OII, ME	шутрпе	Ща	ite) II	HLOX	icacion					
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<ul><li>b.</li><li>Due to (or as a consequent</li><li>c.</li><li>Due to (or as a consequent</li></ul>												
ian and		X UNPENDED	d. AMENDED	220 27	200 f	: norMT	COE	/1:	2/06	יווידוי					
ean centrate be executed attending physician and for use as the burial - transit	ciar	item# 23a,27,28a-f,perME, 685, 4/12/ IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1								23d, Date of delivery					
by the	Physi	Part II. Other significant condition		not resulting	g in the ur	nderlying cau	se give	en in Part	I.	23e. Did to	obacco use contrib	ute to the ca	use of death?		
signed by the atte										1 Ye	s 2 No 3	Probably	4 Unknow		
has beer 2 shoul	Completed by									24a. Was autop perfo	osy pr rmed? de	ior to comple ath?	findings availabilition of cause o		
	ပိ	25. Was case referred to medical				26 P	ace of	Death (C	heck o		2 No 1	<b>✓</b> Yes	2 No		
After this certificate uneral director, page	ŏ	examiner? 1 Yes 2 No	Hospital: 1 Inpatient	2 🗸 ER/0	utpatient		1				Residence 6	Other:			
After t	<u> </u>	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b.	Time of In	jury 28c.	Injury a	at Work?	2	8d. Describe	how injury occurre	d			
after death  Director: After this certif I in by the funeral director,	Certification:	Natural 5 Pending Accident Investig  Natural 5 Pending Investig	gation Fnd 4/3/2006 anot be Place of Injury -		12:15 arm, street	AM -		$2 \times N$		28f. Location (	took overdo Street and Number State) 2005 0	or Rural Ro	ute Number, C		
24 hours Funeral tely filled	Medical Cer	4 Homicide  29a. Certifier 1 Certifying Physical Check only	ined (Specify) Found sician: To the best of my kno ner: On the basis of examinat		ath occurr	ed at the time				Finksbu	rg, MD se(s) and manner a	as started.			
To the complete	Med	29b. Signature and title of certifier	and manner stated.			29c Lic					29d. Date signe				
1		Carort	tallan.	wd			C.M.				April 3, 2006	_			
		30. Name and address of person who Carol Allan, MD Assi	no completed cause of death istant Medical Examin		Penn	Street, Ba	Itimo	re, MD	2120	1					
	ate	31. Date filed (Month, Day, Year)	32 Registrar's Si												
Regist	,	APR 0 5 20	006 Blown		Good	W.									
17 Rev 1/2	001			OR	IGINAL	_									

DHMH 17 Rev 1/2001 OCME 10/2003

			For State Registrar	State o	f Marylan		artmen <i>rtificat</i>		ealth and N Death	_	giene Reg. No:	06	1337		
			1. Decedent's Name (First, Middle, Last	)						2. Date of De. Month	ath Day	Year	3. Time of Death		
	Physici		MILDRED E. PH	IPPS						MARCH	22, 2		2:30P M		
	/Medic Examin		4a. Facility Name (If not institution, give		mber)		4b. City,	Town, or	Location of Death	1 4 4 (0.1		unty of Death			
	LAGITIII	-	1404 OAK BLUFF R	$\Delta D$			EDGEV	יידיר∆זי	•		ZVIVIE	E ARUNI	ET.		
	Funeral		5. Social Security Number 6. Se		7. Age (In yrs.	last birthday)	If Under	1 Year	If Under 24 Hrs.	8. Date of Birt	th	9. Birth	place (State or Foreign		
	Director			JM 2□ <b>X</b> F		79 Yrs.	Months	Days	Hours Min.	(Month, Da FEB.15	1927	NEW I	HAMPSHIRE		
			Usual Residence of Decedent							1.250	7.2				
	* = 1		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits		
2	Mail Mail	ģ	MARYLAND ANNE ARU	MIDET	יבירוים	EWATER							1 ☐ Yes 2 ☐ No		
1	288	Director	10e. Street and Number	בוינוכואו		CANCELLY	10f. Zip	Code			10g. Citizen	of What Cou	ntry?		
4	within 72 nous atter death with the maryland then "natural", or Iteme 23e or 28e-f ehow he Medical Examiner must be notified at		1404 ON DITTED DO	7 D			210	27			T INTTITUTE!	O STATI	PC		
4	1 2 2 E	Funeral	1404 OAK BLUFF RO		edent Ever in U	.S. 13.1	210 Was Dece		spanic Origin? (Sp	ecity Yes or No		Race · Ameri			
	1 1 1	ä	1 Never Married 2 Married	Armed Fo 1 ☐ Yes			f Yes, spe	cify Cubar	n, Mexican, Puerto	Rican, etc.)		Black, White,	etc.		
5-0036	10,12	by	3 Widowed 4 Divorced	1 □Yes If Yes, Gi Year or D	ve X Dates:		1 🗌 Yes	2∏ No	Specify:		Sp	ecity: WHIT	rier		
۶ į	in the		15. Decedent's Edi	ucation		16a. Deced	dent's Usua	al Occupa	ition		16b. Kind	of Business/Ir	<del></del>		
j J	a di	Completed	(Specify only highest grad	le completed)		(Give	kind of wo	rk done d	uring most of work	aing					
212	- th	E	Elementary/Secondary (0-12)	College (	1-4or 5+)	OFFIC	יבי אוא	IACER			RADIC	)			
	Hygir Ther Int.		17. Father's Name (First, Middle, Last)			OFFIC	ידי וידע		18. Mother's Nam	e (First, Middle,					
ם מ	od o	Be C	THATTO CO CONTINUE						FLORENC	בי דייייייייייייייייייייייייייייייייייי					
Maryland	is 1 and 2 should be lined within 72 hours after bearti with the marysal freestift and Member Hygiene. If the marked other than "natural", or Iteme 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at	ို	ELMER C. CANTIN  19a. Informant's Name/Relationship (T	vna. Print)		19b. Mailir	na Address	(Street a	nd Number or Rui		er. City or To	wn. State, Zii	p Code)		
Z Z	h an 7 le i				TTTTCDAND		•			EDGEWATE			,		
	s i and f Health item 27 other ti		LECTURED CALVERT PR	HIPPS (		Place of Dispo				Date		on - City or T	own, State		
altimore,			1 ☐ Burial 2 ☐ Cremation 3 ☐			cemetery, crei			9)						
ב ב	permit. Page Department of Importent: If any injury or once.		4 Donation 5 Other (Specify		KAI	AS CRE			03-2	4-06	FOGEW	ATER, N	ID		
39	epar npor ny in		21. Signature of Full and Heroise 1966)	198					s of FacilityGEO			FUNERA	L HOME		
<u> </u>	7 O E € 0		mag.	604					ONS ISLA			WATER,	MD. 21037		
т			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that one cause on o	caused the deat each line.	th. Do not ent	er the mod	le of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between		
P	nysician		Immediate Cause (Final disease or condition	. 4	Interi	er 1	myod	ind	Vial in	tarat	Gon		Onset and Death		
	/Medical		Immediate Cause (Final disease or condition resulting in death)  a. Anterior myocardial, interction  Due to (or as a consequence of):  Cormon or or for Air cardinals.												
	Examiner		Commentation line and distance	. 6	crono	vy	av.	f-v	y di	is cal	-				
		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	(or as a conseq	juence of):		15	/						
	oute outer	Examin	that initiated events	С.											
o	exe en ar rial-t	ũ	resulting in death) Last	Due to	(or as a conseq	juence of):									
8760	cale be executed physicien and the burial-transit	dlcal	(	d											
89	g ph as th	ed									1				
ă	ndin use	2	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna						23d	. Date of deliv	very		
.O. Box	that the death certified by the attending detached for use as	Physician/Me	in the past 12 months?	4□Preg	birth 2□Feta nant at time of d		_lEctopic p _lOther (sa					Month	Day Year		
0	ne ne ne ne ne ne ne ne ne ne ne ne ne n	hys	9 ☐ Unknown	9□ Unkr	own										
<u>.</u>	Attending Physicien: The law fequires that the deam certific death: The death.  ector: Alter this certificete hes been signed by the attending by the funeral director, page 2 should be detached for use as	by P	Part II. Other significant conditions co	ontributing to d						23e. Did t	obacco use	contribute to	the cause of death?		
Division of Vital Records,	ures Sign	9	Stroke	HTN	hy	porli	pick.	em,	`	10	Yes 2□N	lo 3□Pro	bably 4 Unknown		
ō.	w require been signature should b	ete			1 /1	, ,				24a. Was	an 2	4b. Were aut	opsy findings available		
Ä.	he lay	Completed									ormed?	death?	opsy findings available ompletion of cause of		
_ <u>_</u>	cete									1 Yes	a₽ No	1 🗆 Yes	2□ No		
5	sicien: The law s certificete hes t irector, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:				Othe	26. Place of Dea						
5	this al dir	၉	1 ☐ Yes 2√∑ No  27. Manner of Death	. 10		ER/Outpatier 28b. Time o		JA	4   Nursing H	ome 5 Resi 28d. Describe			ify)		
ב	Alter funera	0	1 ☑ Natural 5 ☐ Pending		nth, Day Year)	Injury	' м	28c. Injury Work		zou. Describe	now injury o	COMPO			
Sic	tend leath tor: ,	cat	2 Accident investigation 3 Suicide 6 Could not be						Yes 2 □No	29f Looption (	Street and A	lumber or Ru	ral Route Number,		
<u> </u>	or Attendate after death	Certification:	4 Homicide determined	288. Plac	e of Injury - At h ling, etc. <i>(Speci</i> l	fy)	reet, factor	у, опісе		City or To		umber or Aur	ar noute romber,		
	urs a		10.000		TO COLUMN AND LONG TO SECURE							dina su su su aliana			
	Fune Fune Flune	edical	(Check only 2 Medical Exam	iner: On the b	pasis of examina	ation and/or in	vestigation	i, in my or	pinion, death occur	rred at the time.	date and pla	ace, and due	to the cause(s)		
	To the Hospitel or Attending Physicien: The within 24 hours after death.  To the Funeral Director: Attenthis certificate he completely filled in by the funeral director, page	Med	one)	and mar	nner stated		20	c. License	number		29d Date s	ianed (Manth	Day, Year)		
	S T X S		250. Signature and que or definer	1///	$/\!\!/$		23		1418/1	2	200. Daile 3	.aa. /ma.m.			
,			Chen	KK	(m)			V	, , , , , , ,		MARCH	23,200	)6		
			30. Name and address of person who	completed cau	e of death (Iter	m 23a) (Type,	Print)		· T:/	0 2.0	Anna	-mulic	MD 21401		
			30. Name and address of person who all the filed (Month, Day, Year)	4-1/11	Pagin de Si-	17 0/0	10/0	- vn u	- I reno		- 1-1		' /		
	Sta Regist		21. Date filed (Month, Day, Year)	4 2006	MARIA SOUTH	J. J.	Show	Les or							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** March 21, 6:15 P M 2006 L. Trene Piqman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 2707 Riva Road Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 X F Director 036-18-6972 82 Dec. 20,1923 Ohio Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ir then "natural", or Itams 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 No Edgewater Director Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth with Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "--- any injury or other treument—any injury or other treument—any 2023 Shore Drive 21037 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: ð 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Decupation Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Chemistry Professor Education 5+ 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Pretzer Hanna Reutnick ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nathaniel M. Pigman, Jr./Husband 2023 Shore Drive Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Kalas Crematory 3-23-06 Edgewater, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Jury gel Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road Edgewater, MD, 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Diratory disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ettending physicien and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 9 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2. No 1 Yes 2 No : After this certification of funeral director. To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) ASSISTED examiner? Other: 4 Nursing Home 5 Residence 6 ther (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 27. Manner of Death 28b. Time of 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. М investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Medicai 29a. Certifier 🕊 🚅 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0025499 nd address of person y to completed cause of death (Item 23a) (Type, Print) Ritchie Highway Arnold, MAZIO12 M. 32. Registrar Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Physician 20, Mar. 2006 12:00 pm Elsie May Phipps /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner Crofton Anne Arundel Crofton Convalescent Center if Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 1 □ M 2 🖫 F Yrs 84 Director May 2, 1921 214-14-8515 Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours efter death with the Marylend Department of Heelth and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. fnside City Limits 10a. State 10b. County 1 ☐ Yes 2√2 No MD Anne Arundel Crofton Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2131 Davidsonville Road 21114 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 🔯 No If Yes, Give 1 Never Married 2 Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: Completed by 3 X Widowed 4 □ Divorced Year or Detes 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) **Home** Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lucie Hutcherson Emitt Baber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. fnformant's Name/Relationship (Type, Print) Sherry Arigo/Daughter 1562 Comanche Road, Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Mar.23, 1 Burial 2 □ Cremation 3 □ Removal from State Elkridge, MD Meadowridge Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foneral Service Licensee Barranco & of Facility Sons. Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Part 1. E for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. **Physician** CARDIOVASCULAR DISEASE mmedia Cause (Final diseas, or condition e ming in death) /Medical MINUTES Examiner Be Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Lest Due to (or es a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) Medical Certification: To 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Menner of Death 1 A Natural
2 Accident 5 Pending 1 Tes 2 No death. investigation Director: A I in by the fu 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide efter Direc within 24 hours e To the Funeral C completely filled 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Yeer) 29c. License number 29b. Signature and title of certifier MARCH 20, 2006 D31136

Registrar

State

BRIAN

31. Date filed (Month, Day, Year)

MAR 24 2006

4005

KILBRIDE RD, BALTIMORE, MD ZIZZE

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

WALLACE MID

2. Registrar's Signature

			•	•
		State of Maryland / Department of Health	and Mental Hygiene	1000
)r		otato of marytana, popularion of mount	rand moman riygion	
ate	1 1	1 . 1 Martificate of Door	h ac accept a	

			1- State Registrar Amended ite	em 4a per m	e/wichd <i>©e</i> /	tificate of	Death3-28-2	2006/d1 <sub>fs</sub>	ig. No.	11340
	Dhunini		1. Decedent's Name (First, Middle, La	st)		<u> </u>		2. Date of Death Month		3. Time of Death
	Physici /Medio		Michael [	)ouglas	Powell			March		6:53 A <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, give				r Location of Death		4c. County of Death	
			30975 Carioca Ro	ad	da en la desirabilità de 1	Deln If Under 1 Year		0.5 (5:4)	Wicomic	
	Funeral Director		5. Social Security Number 6. S 222–62–1065	Y-11	(In yrs. last birthday) 25 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 6/24/198	Year) 9. Birth Cou	place (State or Foreign intry) land
	Pu ≥		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or Lo	cation				40d Inside City Limits
	ehov	5	Maryland Wicomic		Delmar	Cation				10d. Inside City Limits 1 ☐ Yes 2 No
	28a-1	ect	10e. Street and Number		Delilar	10f. Zip Code		10	og. Citizen of What Cou	
	with with	급	30975 Carioca	Road			1875	10	USA	muy :
	ns 23	era	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13. V			city Yes or No-	14. Race - Amer	ican Indian.
21215-0036	s 1 end 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 ie marked other then "naturel", or items 23a or 28a-f show other traumatic event, its Medical Evarinar must be notified at	by Funeral Director	1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 ☐ Yes 2🛣 No	tispanic Origin? (Spe an, Mexican, Puerto F Specify:	Rican, etc.)	Black, White Specify: wh:	, etc.
ĕ	2 hou	ted	15. Decedent's Ed	ducation	16a. Deced	ient's Usual Occup	pation	1	  6b. Kind of Business/I	ndustry
215	hin 7	Completed by	(Specify only highest gra	completed) College (1-4or 5+			during most of working d)			
7	giene er th	NO.	12		Glas	s instal	ler/glazer		Glass comp	pany
nd	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, Last) Douglas Elwood P				18. Mother's Name		faiden Sumame)	
Va	Ment Ment Prke	2		Owerr			Jean An	n Hitch		
Maryland	2 sh and ie m	1	19a. Informant's Name/Relationship (						City or Town, State, Zi	p Code)
	l end lealth m 27 her ti		Douglas E. Powell	/iather			a Rd., Del	-		
Baltimore,	permit. Pages 1 end 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other then eny Injury or other traumatic event, IL a Magnee.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of Dispo cemetery, crem Salisbury		ory 3/29		Salisbury,	
alti	mit.		21. Signature of Funeral Service Licer	1500						
ď	Depa Impo eny ir		David H.	Dompson	CFSP	501 Snow	Hill Rd.,	Salisb	ury, MD 218	Association 304
			2 a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to	he death. Do not ent	er the mode of dyir	ng, such as cardiac or	r respiratory arre	st,	Approximate Interval Between
Y.	Physician /Medical	9	Immediate Cause (Final disease or condition resulting in death)	a ASPH	ALXY					Onset and Death
	Examiner			h HANG	consequence of):					
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury		consequence of):			· · · · · · · · · · · · · · · · · · ·		······································
	outed Id ansit	Examiner	Cause (Disease or injury that initiated events	c						
ó	tificete be executed ig physicien and as the burial-transit		resulting in death) Last	Due to (or as a	consequence of):					
68760,	ste be	Medical	•	d						
	ng ph as t	Med	IF FEMALE:							
O. Box	et the death certificete be executed by the ettending physicien and teched for use as the burial-transit	Physician/	23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti	☐Fetal death 3☐	Ectopic pregnancy Other (specify)	, , , , , , , , , , , , , , , , , , , ,		23d. Date of deliv Month	ery Day Year
s, P.O	as the	by Ph	Part II. Other significant conditions of	ontributing to death but	not resulting in the ur	nderlying cause giv	en in Part I.		acco use contribute to	
of Vital Records,	w require been sig should b	ted						1 Te	s 2 <b>Ø</b> No 3□Pro	babiy 4 □Unknown
e C	has b	Completed						24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
=	ate pag	S						perform 1 Yes 2	led? death? □ No 120 es	2 □ No
Vita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Liganital			26. Place of Death	(Check only one	)	
of	Phys this al dii	၉	1 X Yes 2 □ No	Hospital:			4   Nursing Horr		nce 6 Other (Speci	fy)
Division	ding h. After tune	Certification:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	7/00/01	6 TOURD S	70 M 1 □			w injury occurred T FOVND +	eangi NG
ĬŽ	or At fter d blrect n by	E E	3 Suicide 6 Could not b 4 Homicide determined	building, etc.	y - At home, larm, stre (Specify)			City or Town	eet and Number or Rur State)	_
	pital		00- C-48 15 0 -41	OUTSIDE					UDGA RD, DE	
	To the Hospital or Atten within 24 hours after deat To the Funerel Director: completely filled in by the	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ XMedical Exam	ysician: To the best of niner: On the basis of e and manner state	xamination and/or inv	occurred at the tin restigation, in my o	ne, date and place, a pinion, death occurre	nd due to the ca d at the time, da	use(s) and manner as s te and place, and due t	stated. o the cause(s)
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of certifier	V .		29c. Licens	e number	29	d. Date signed (Month,	Day, Year)
	B		> Cue	\$5.		C	O.C.M.E.		March 2	6, 2006

State Registrar

DHMH 17 Rev 1/2001

ANA RUB10, TD

31. Date filed (Month, Day, Year)
MAR 2 8 2006

32. Fegistrar's Signature

111 Penn Street Baltimore, Maryland 21201

			1 State		epartment of H			2.0	0.6	1131.1
			Registrar  1. Decedent's Name (First, Middle, Last)		Certificate of I	Dealn	2. Date of Dea	Reg. No. U	UU	3. Time of Death
	Physici	an	Chong O. Park				Month ,	Day	Year	1.1
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City. Town, or	Location of Death	MARKET	26 4c. Cou	200C unty of Death	1415 M
	Examir	iei	Partituin Regional Medical 1	1/11/	-	136 VAL			Vicom.	-
i	Funeral			yrs. last birth		ff Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Da)	h Voor)	9. Births	place (State or Foreign
	Director		217-78-1186 10M 2RF 86	Yı	rs. Moritis Days	rivais Mili.	7/24/19	919	Kor	
	and *		Usual Residence of Decedent           10a. State         10b. County         10c	c. City, Town	or Location					10d. Inside City Limits
1	Manyli f eho	ō	Maryland Wicomico	Salis						1 ☐ Yes 2X No
8	28a	rect	10e. Street and Number	Dullb	10f. Zip Code			10g. Citizen	of What Cour	ntry?
1	Illed within 72 hours after death with the Maryland Hygiene. Hygiene. I have not then "naturel", or Iteme 23a or 28a-f show ont, the Madical Exam. Art must be notified at	Funeral Director	6174 Augusta Circle		21801			US		•
00	deat	ner	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S.	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No-	14.	Race - Americ Black, White,	
3 %	or It		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No		1 ☐ Yes 🔏 ☐ No	Specify:	Thours, oto.;		ecify:	Korean
2/12	hours ture!	ed by	3 Widowed 4 Divorced Year or Dates:	160 5	December 11 - 11 - 12 - 12 - 12 - 12 - 12 - 12					
1/2 K	n 72 n n	plet	(Specify only highest grade completed)	100. 0	Decedent's Usual Occupa Give kind of work done of life. DO NOT use retired	during most of work (1)	ing	IBD. KING C	of Business/In	idustry
6 5	d with	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	1	harmacist	,		Ph	armacy	
3 5	be file stal Hyg d oth	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle,	Maiden Sun	nam <i>e)</i>	
CHANG anyland 2	should b ind Menta marked umatice	To	Yong H. Park			Insoo I	ree			
7	2 sh and lem		19a. Informant's Name/Relationship (Type, Print)		Mailing Address (Street a					
PARK, CHANG 217-	is 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene.  If the man arked other than "nature!, or Items 23a or 28s-1 show other treumatic event, the Madical Examinar must be recitified.		Chinsoo Park/son  20a. Method of Disposition		174 Augusta Disposition (Name of		Salisou		on - City or To	
स्में	or o		1 XBurial 2 Cremation 3 Removal from State	crematory or other plac CO Memorial	e)	3/06		bury, 1		
1	permit. Peges Department of Important: If it eny Injury or once.		4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service Lix niee	Park	22: Name and Addres					
ä	# 0 m m		Kentle FC Newrow (FS)	P	501 Snow	Hill Rd.	Salisb	ury,	onal A MD 218	ssociation 04
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	death. Do no						Approximate fnterval Between
	Physician		Immediate Cause (Final disease or condition	515						Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a cor	nsequence of		011-				- 1
	Examiner	_	Sequentially list conditions, if any, leading to immediate  Due to (or as a cor	KAT	, ,	5CUS				78
	ited	Examiner	Saquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	isequence or,	).					
_	execu n end ial-tra	Exar	that infliated events resulting in death) Last c. Due to (or as a cor	nsequence of	):				_	
8760	ficate be executed physicien end s the burial-transit	dicai	d					_		
4	्र च ठील	Med	IF FEMALE:							
Š	eath certif ettending for use as	an/	23b. Was decedent pregnant in the past 12 months?	egnancy Fetal death	3 ☐Ectopic pregnancy			23d.	Date of delive	•
C	by the e	Physician/Me	1 Yes 2 No 4 Pregnant at time 9 Unknown 9 Unknown	of death	5 Other (specify)				WORTH	Day Year
۵	thet the od by detac	g.	Part II. Other significant conditions contributing to death but not	t resulting in t	he underlying cause give	en in Part I	23e. Did to	bacco use c	contribute to the	he cause of death?
4	uires the signed Id be de	d by	HISTORY OF MULTIPLE CV	45	,,,			es 2 No		- 1
j	w requir been si should	lete					24a. Was a	n 24	b Were auto	onsy findings available
a d	The lav	Completed					autop: perfor	med2	death?	opsy findings available impletion of cause of
<u>.</u>	ilcian: Th certificete rector, pag	0	25. Was case referred to medical			26. Pface of Death		200 No	1 🗌 Yes	2 No
>	examiner?    Comparison   Compa								Other (Specif	(y)
2	28d. Describe how injury occurred (Month, Day Yeer) 28b. Time of 28c. Injury at Work?								curred	Think to the state of the state
<u> </u>	Attendideath.	cat	2 Accident investigation			Yes 2 No				
Ž	lor A after Direct	Certification:	4 Homicide determined 288. Place of Injury - building, etc. (Sp.	ecify)	n, street, factory, office		City or Tow	treet and Nu n, State)	m <i>ber</i> or Hura	al Route Number,
	Hospital or 24 hours afte Funerel Dir itely filled in		29a. Certifying Physicien: To the best of my	knowledge, o	death occurred at the tim	e, date and place,	and due to the c	ause(s) and	manner as s	tated.
	To the Hospital or Attendi within 24 hours attendeath. To the Funerel Director: A completely filled in by the fu	Medical	one) 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/	or investigation, in my op	pinion, death occurr	ed at the time, o	late and plac	e, and due to	o the cause(s)
	To the within ?	Σ	29b. Signature and little of certifier	MD	29c. License	number	2	29d. Date sig	gned (Monjh,	Dey, Year)
	100		1000		D	7106/		2	12/10	16
	Xo		30. Name and address of person who completed cause of death  NICHO 45 T D UDAS	(ftem 23a) (Tr	ype, Print)	ST 5	AL15B	RY	MD	21801
	Sta	te	31. Date filed (Month, Day, Year) 32. Sigistrar's S	ignature	- FINALL	, ,	,,000			
	Registr		MAR 2 8 2006	K.	book					

				State of Ma					•		•	
			1 - State Registrar Amend#1.RerPh	ws.PGC 3-24	4-06 cr		tificate of			Reg. No	11165	11342
.5	A.		1. Decedent's Name (First, Middle, Last)	Ruth		2011	ton		2. Date of De	ath Da	y Year	3. Time of Death
	Physici /Medic		Peyton Ruth A.		A. F	еу	ton		March	17t	h 2006	
1	Examin	er	4a. Facility Name (If not institution, give s		4 4 - <b>1</b>			or Location of Death	1		. County of Dea	
			Southern Maryla 5. Social Security Number 6. Sex		ıta⊥ e (In yrs. last birth		Clintor If Under 1 Year	If Under 24 Hrs.	8. Date of Bir		ince G	
	Funeral Director			M 25kF 89			Months Days	Hours Min.	(Month, Da	y, Year)	16 Was	thplace (State or Foreign buntry)
	pu >		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	05100	ention		2.001 2			10d. Inside City Limits
	Aaryla Febor	o.	Md Prince G	George	Temple							1 XYes 2 No
	28a-	rect	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Co	ountry?
	h with	Funeral Director	5505 Huntland Rd	i			20748			US	SA	
	eme.	ıner	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. W	/as Decedent of H Yes, specify Cub	dispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	-	14. Race - Ame Black, Whit	
036	d within 72 hours after death with the Maryland plene. I then "naturel", or Iteme 23a or 28e-f ehow the Madical Examiner over the notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🙀 N If Yes, Give Year or Dates:	ło		□Yes 2X No				Specify: B	
5-0	72 ho	Completed	15. Decedent's Educ (Specify only highest grade		16a. E	Decede Give k	ent's Usual Occur and of work done	pation during most of wor d)	kıng	16b. K	and of Business	/Industry
12	within ene.	дшо	Elementary/Secondary (0-12)	College (1-4or 5	+) Cl			a)		Stat	te Dep	t/Fed Gov'
<u>d</u> 2	I Hygie other	Be Co	12th 17. Father's Name (First, Middle, Last)		101	C	<u> </u>	18. Mother's Nar	ne (First, Middle	Maiden	Sumame)	
ıları	vid be dental rrked c	ToB	James T. Allen					Bessie	Jackso	n		
Maryland 21215-0036	ges 1 and 2 should be filed it of Health and Mental Hyg If Item 27 is marked othe or other traumatic event,	1 1	19a. Informant's Name/Relationship (Typ James Peyton (Son					and Number or Ru Dinte Ct				
Baltimore,	of Head		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	20b. Place of Cometery,	, crem	atory or other pla-	ce)	Date		ocation - City or	_
ij	Pa Int		4 ☐Donation 5 ☐ Other (Specify)		Harmon	_	Mem Par		24/06			MaryLand
Bal	permit. Departin Imports any nju		21. Signature of Funeral Service License	112	8			ess of Facility Wa Young				
			23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations that caused							<u>u, 50.</u>	Approximate Interval Between
ı	Physician		Immediate Cause (Final disease or condition	ATL	ecolond	k' <	Coads	21/086	0 01	10.		Onset and Death
	/Medical		resulting in death)	Due to (or as a	a consequence of	):	anco	nisian	D- ( , , )	200		27.
П	Examiner	ē	Sequentially list conditions, b	Co 1	Te Mo	Vo	sclar	Mislan				15.
	nsit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	a consequence of	).						
Ć	sician and burial-transit	Examin	resulting in death) Last	Due to (or as a	a consequence of	):						
3760,	± > 0	cal	<b>€</b> d									
x 68	The law requires that the death certifica ate has been signed by the attending phrage 2 should be dejached for use as the	Physiclan/Med	IF FEMALE:	2a If was outcome	of aroananou							
Вох	attend for us	clan	in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		Ectopic pregnance Other (specify)	у			23d. Date of de Month	livery Day Year
P.O.	the d by the ached	hysi	1 ☐ Yes 2 ☐No 9 ☐ Unknown	9□ Unknown								
S,	es that igned I be det	ру Р	Part II. Dther significant conditions con	tributing to death bu	ut not resulting in t	the un	derlying cause giv	ven in Part I.	23e. Did t	obacco i	use contribute to	o the cause of death?
brd	w require been si should b								1 🗆	Yes 2	□No 3□P	robably 4 🖫 nknown
Sec	has be	Completed							24a. Was auto	osy	prior to	utopsy findings available completion of cause of
a F						_		·	1 ☐ Yes	rmed? 2) No	death? 1 ☐ Yes	2 □ No
ΖΪ		o Be	25. Was case referred to medical examiner?  1 Yes 28 No	ospital:	nt 2X ER/Outp	ot ont	3 DOA   O#	26. Place of Dea			C []Other (C	
ō	g Phys er this eral di	-	27. Manner of Death	28a. Date of Injur	y 28b. Tir	me of	28c. Injui	rv at	ome 5 Resi 28d. Describe			icity)
ion	Attending r death. ector; After by the fune	atlo	1 Schatural 5 Pending 2 Accident investigation	(Month, Day	7 (947)	ury	M 1□	Yes 2 □ No				
Division of Vital Records,	of or Atter de la Directo	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ury - At home, farn c. (Specify)	n, stre	et, factory, office		28f. Location ( City or To			ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	ledical C	29a. Certifier Check only one)	sicien: To the best of ner: On the basis of and manner sta	examination and/	death or inve	occurred at the till estigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s date and	) and manner as d place, and due	s stated. e to the cause(s)
	within To the comple	Me	29b. Signature and title of certifier				29c. Licens				ite signed (Moni	
	6		m8h				0	45365			3-20-	-
2	(5)		30. Name and address of person who co	mpleted cause of de	eath (Item 23a) (T	ype, F	Print)		- 09/	د (	0761	/
-	-		Misidanousimo 11701	11/1091/2	TV H	101	1tt h	43 Cing T	from 1 for		J. 7 9	

Registrar

31. Date filed (Month, Day, Year)
MAR 2 4 2006
MAR 2 4 2006
MAR 2 4 2006

State of Maryland / Department of Health and Mental Hygiene () () 5 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 0445 M Puhalla Donald /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death SOCRED HEART HOSPITAL ALLEGANY CUMBERLAND If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth Month, Day, Oct 23, 9. Birthplace (State or Foreign Country) **Funeral** Days Months Min. 1 M 2 □ F Hours 1935 Director 217-30-2020 70 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits in than "naturel", or Items 23a or 28s-f ehow the Medical Examinar must be notified at Allegany MD LaVale Director 1 Ves 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 15 N. LaVale Street death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: Specify: white à 1958-62 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 clerk railroad other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Depertment of Heelth and Mental Hy Important: if Item 27 is marked oth eny liqury or other traumatic event potes. 18. Mother's Name (First, Middle, Maiden Sumame) Be John Puhalla Eva Rosella Hutchinson Puhalla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Puhalla wife 15 N. LaVale Street LaVale MD 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Buriat 2 □ Cremation 3 □ Removal from State St. Patrick's Cemetery 4/7/2006 MD Cumberland 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Me Physician Wesh a cinoma 6 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospitel or Attending Physician: The law requires thet the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. ettending physiclen by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the etten e detached for u 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မှ 1 ☐ Yes 2 Z No 1-1 Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification 1. Watural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death 2 Accident efter death completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours e To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and life of certifier 29c. License number 29d, Date signed (Month, Day, Year) Horel 00033280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kent Avenue Combercand, MD 21502 R. SUNII 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State APR 1 1 2006 Registrar

			For State Registrar	State of M	larylan	•			ealth a D <i>eath</i>	nd Me		giene		11344
			Decedent's Name (First, Middle, L.	ast)				-		2.	Date of Dea	ath		3. Time of Death
	Physicia		ELIZABETH M.	PANCAKE							Month MARCH	Day 1 28TH,	Year 2006	16:00 M
	/Medic Examin		4a. Facility Name (If not institution, gi		)		4b. City,	Town, or	Location of	Death		4c. County		
			MEMORIAL HOSPITA	I.			CUM	BERL	AND			ALLEG	GANY	
	Funeral		5. Social Security Number 6.	Sex 7. A	ge (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2 Hours	Min.	Date of Birt (Month, Day	v. Year)	9. Birthp Coun	lace (State or Foreign try)
	Director		234-44-683/	1□ M 2∏F	76	Yrs.				J	AN. 30	, 1930		ÉŔ, WV
	pu 🖈	}	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
	aho	5			100.00								Ι'	1 ☐ Yes 2 📆 💢 o
	ha N 28a-f	Director	WV MINEI  10e. Street and Number	RAL		RIDG	ELEY 10f. Zig	Code			Т	10g. Citizen of	What Cour	
	a or	급		3			101. 21		F 2			-		uy:
	daath with tha Maryland ms 23a or 28a-f ahow r muat be notified at	Funeral	RT. 1, BOX 81-0	12. Was Deceden	t Ever in U	S 13 1	Was Dece	267		in? (Specif	v Yes or No	USA 14. Bas	A ce - Americ	an Indian.
_	Item Item	'n.	1 ☐ Never Married 2 ☐ Married	Armed Forces	?		f Yes, spe	cify Cuba	n, Mexican,	Puerto Rio	y Yes or No- can, etc.)	Bla	ck, White,	
2000	urs af	by	3 ☐ Widowed 4 【X Divorced	If Yes, Give X Year or Dates:			1 🗆 Yes	2 <b>X</b> ) No	Specify:			Specia		ITE
5	within 72 hours aftar ana. than "netural", or Ite hedical Examine	Completed	15. Decedent's i			16a. Dece	dent's Usu	al Occupa	ation	-4		16b. Kind of B		
7	hin 7	ple	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT u	se retired	luring most )	or working				
\ \	e filed within al Hygiana. I other than '	) Du	12		<u> </u>	CO	OK					COUNTY	SCHOO	OL SYSTEM
2	be filed ital Hygi d other event, I	Be (	17. Father's Name (First, Middle, Las	st)					18. Mother	r's Name (F	First, Middle,	Maiden Sumai	me)	
yıand	should trud Mant	2	ROBERT M. MONO	GOLD		.,			ZET'	TA E.	BOWMA	AN		
Mar	2 should be and Mantal is marked of reumatic eve		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Address	(Street a	and Number	r or Rural P	Route Numbe	ar, City or Town	, State, Zip	Code)
≥ .	D = 0 = 0		GERALD B. PANCAR	KE/ SON			5, BO		8 K	EYSER		26726		
9	pas 1 an of Haal If Item 2 or other		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3	☐Removal from State	1 ~	Place of Dispo cometery, crer	sition (Nai natory or c	me of other plac	9)	APR		20c. Location	- City or To	wn, State
Баппр	armit. Pagas apartmant of a aportant: If It by injury or o		4 □ Donation 5 □ Other (Spec			OMAC M	EMORI	AL G	ARDEN	-	006	KEYSEI	R, WV	
<u>a</u>	permit. Dapart Import eny inj		21. Signature of Funeral Service Lice	ensee					s of Facility			UNERAL	_	
_	# Q E # B		Prise t	Sull			85 SO	UTH	MAIN	STREE	T KE	EYSER, V	V 2	26726
			23a. Part1. Enter the disease, or con shock, or heart failure. List onl	mplications that cause ly one cause on each	d the deat line.	h. Do not ent	er the mod	de of dying	g, such as c	cardiac or r	espiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Adult	Respi	ratory	Dist	ress	Synd	rome				30 days
	/Medical		resulting in death)	Due to (or a										
	Examiner		Sectionality list conditions.	Pseudon			Colit	is						30 days
	p #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or a	•									
4	and trans	Examin	Cause (Disease or injury that initiated events resulting in death) Last	c. Retain			e in	Abdo	men w	ith F	'istula	1	-	6 months
Y nove	ba axacuted ician and burial-transit			Due to (or a	s a conseq	derice or):							- P	
		dical	•	d										
×	iaw raquiras that the daath cartificata as baan signad by the atlanding phys 2 should be datachad for usa as the	/Med	IF FEMALE:	23c. If yes, outcom	e of pregna	ancv						024 D		
X D	attan for u	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant	2 Feta	ldeath 3□	Ectopic p						ate of delive onth	Day Year
j	the di	Physician/M	1 ☐ Yes 2 █ No 9 ☐ Unknown	9□ Unknown	21 11110 01 0	oam oc	7 O(1)61 (3)	<i></i>						
7	that ad by data		Part II. Other significant conditions	contributing to death	but not res	ulting in the u	nderlying o	ause give	en in Part I.		23e. Did to	obacco use con	tribute to th	e cause of death?
S	uiras I sign Id be	d by	Right Pneumother	rapy Due to	o Bar	otraum	a-ven	ntila	tor,		101	res 2 ☐ No	3 ☐ Prob	ably 4 Qunknown
cords	v raq baar shou	ete	Chronic Pulmonary	z Incuffic	iones	Subt	otal	Colo	ctomy		24a. Was	an 24h	Ware auto	psy findings available
ě	has ga 2	Completed		y Insultic	rency	, Subt	Otal	COTE	CCOmy	_	autop perfo	rmed?	prior to con death?	mpletion of cause of
NI I	sician: The lar cartificeta has ractor, paga 2	e Co	with Ileostomy 25. Was case referred to medical	1						45	1 ☐ Yes		1 🗆 Yes	2□ No
5	Physician: r this cartific ral diractor,	00	examiner?	Hospital: 1 Inpat	iont 2	ER/Outpatier	nt 3 DC	Othe	ar-		Check only o	<i>ine</i> j dence 6 ⊟Oti	has (Casa)	
	Phy ir this aral d	To :r	27. Manner of Death	28a. Date of Inj (Month, D		28b. Time o		28c. injury Work	4 🗆 1401			now injury occu		//
0	th. : Afte	ig I	1 Natural 5 ☐ Pending 2 ☐ Accident investigati		ay Year)	Injury	М		c? Yes 2.∐N	No				
DIVISION	of Attending efter death. I Director: Aftai d in by the fune	fica	3 ☐ Suicide 6 ☐ Could not	286. Place of it	njury - At h	ome, farm, str	eet, factor	y, office		28	f. Location (5	Street and Num	ber or Rura	I Route Number,
É	eftar Dire	Certification;	4 - Homicide determine	building, e	etc." (Specif	<b>(y</b> )					City or Tov	vn, State)		
	Hospital		29a. Certifier 1 Certifying F	Physician: To the bes	t of my kno	wledge, deat	h occurred	at the tim	ne, date and	d place, and	d due to the	cause(s) and m	anner as s	ated.
	ne Ho ne Fu	Medical	(Check only 2 ☐ Medical Example)	aminer: On the basis and manner s	of examina stated.	ition and/or in	vestigation	i, in my or	oinion, deat	h occurred	at the time,	date and place,	, and due to	the cause(s)
	To the Hospital or Attending Physician: The i within 24 hours eith death. To the Funeral Director: After this cartificate he complately filled in by the funeral director, page	Ž	29b. Signature and title of certifier	1			29	c. License	number			29d. Date signe	ed (Month,	Day, Year)
			1/1/1/	tchuses					D1745	6		5/2	7/0	4
	1		30. Name and address of person wh	o completed cause of	death (Iten	n 23a) (Type,	Print)						/	
	ン		SCHROEDER, PHILI	IP J., M.D.	, 60	0 MEMO	RIAL	AVEN	UE, SI	UITE	402, C	CUMBERLA	AND, N	ID 21502
	Sta		31. Date filed (Month Day, Year)	062. Regis	trar's Signa	ature	160							
	Registr	ar	ALL TO CO	UU ARM	, JU	STORY								

			State of Maryland / Department of Health at 1- Registrer Certificate of Death		giene neg No.006   1345
			Decedent's Name (First, Middle, Last)	2. Date of Dea	ath 3. Time of Death Day Year
п	Physicia /Medic		Bernard Leroy Pierce AKA Leroy Bernard Pierce	Month	22. 2006 6:20 P. M
	Examin		4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of	Death	4c. County of Deeth
			Mariner Health Care of Laurel Laurel		Prince George's
н	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 12 F 82 Yrs.  13 Months Days Hours	Min. 8. Date of Birth (Month, Day 12/15/	9. Birthplace (State or Foreign Country)
	Director	-	Usuel Residence of Decedent	12/15/	Seabrook, Md.
	/land		10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	Many Many	tor	Md P.G. Laurel		1 ☑ Yes 2 ☐ No
	th the	irec	10e. Street and Number 10f. Zip Code		10g. Citizen of What Country?
	23a	rai	14200 Laurel Park Drive 20707		U.S.A.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ No If Yes, Give Year or Dates: 1943	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. African— American
2-0	72 ho	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of	of working	16b. Kind of Business/Industry Government Printing
7	ithin	Completed	Flementary/Secondary (0-12) College (1-4or 5+)		Office
2	lled w tygier her th		7th Printers Assistant  17. Father's Name (First, Middle, Last) 18. Mother	's Name (First, Middle,	U.S. Government
anc	ntal hed ot	Be			Walden Sumame)
Maryland	thould nd Me mark matic	٩	George Pierce, Sr. E]  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number	llen Bell r or Rural Route Numbe	r, City or Town, State, Zip Code)
Σ	th ar 1th ar 27 is r trau		Mary C. Reed/Daughter 3460 24th St., S.E.,		
ē,	f Hea item other		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery company or other place)	Date	20c. Location - City or Town, State
Baltimore,	Page lent o nt: if ry or		1 ★ Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)  Maryland Veterans Cem.	3/30/06	Cheltenham, Md.
alti	permit. Departmimports Imports any inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  4. C. Waghington	S Sena Co	Tne
m	8 8 E 8 8		any W. Shar 4925 Burroughs	Ave., N.E.,	Inc. Washington, D.C. 20019
	Pmysician i		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as construction that cause on each line.  Immediate Cause (Final disease or condition a Aspiration Pneumonia	ardiac or respiratory an	rest, Approximate Interval Between Onset and Death 1 Month
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):		
	Lxammer	L	Sequentially list conditions, b		
	led Isit	Examine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Divisase or find y		
	cate be executed physician and the burial-transit	xar	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):		
8760,	cate be ex physician the buria	dicai E	d		
9	ifficate g phy as the	edic			
Вох	death certilicate be executed te attending physician and ad for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery
	ne deat the att hed for	sicis	In the past 12 months?  1 ☐ Yes 2 ☐ No  4 ☐ Pregnant at time of death 5 ☐ Other (specify)		Month Day Year
P.0	t t	Phy	9 Unknown	oo- Dida	the second of death 2
Division of Vital Records,	es pe	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Cerebrovascular Accident		obacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Munknown
000	> 11 0	Completed	Arteriosclerotic Cardiovascular Disease	24a. Was a	an 24b. Were autopsy findings available prior to completion of cause of
R	o - o	mo		perto	med? death?  2 No 1 Yes 2 No
ital		Bec	25. Was case referred to medical 26. Place of	of Death (Check only o	
<u>_</u>	di is	10		sing Home 5 Resid	dence 6 Other (Specify)
n o			27. Manner of Death 28a. Date of Injury 1 (Month, Day Year) 28b. Time of 28c. Injury at Work?		now injury occurred
sio	Attending r death. sctor: After	cati	2 Accident investigation M 1 Yes 2 N		Name of the second state o
$\leq$	ol or Attend after death Director: /	Certification:	Suicide  4 Homicide  4 Homicide  4 Suicide  4 Homicide  4 Homicide  4 Suicide  5 Suicide  4 Suicide  4 Suicide  5 Suicide  6 Suicide  7 Suicide  7 Suicide  8 Suicide	City or Tow	Street and Number or Rural Route Number, vn, State)
	Hospital 24 hours a Funeral I		29a. Certifier 125-Certifying Physician: To the best of my knowledge, death occurred at the time, date and	d place, and due to the u	Cause(s) and manner as stated
	_ ~ ~ ~	edical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.		
	To the I within 2 To the Complet	Me	29b. Signature and title of certifier 29c. License number	(	29d. Date signed (Month, Day, Year)
			D24721		March 24,2006
) [	2)11)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	-	
_	91Va	1	Syed A. Sadiq, M.D. 14333 Laurel-Bowie Rd. Ste. 208	Laurel,	Maryland 20708
	Sta Registr		31. Date filed (Month, Day, Year)  MAR 2.7 2006  MAR 2.7 2006	, 	-

			1 = For State Registrar	State o	f Marylan		artmen rtificat			nd Mer		iene g. No.	16	11346
6	Physici		1. Decedent's Name (First, Middle, I Julie	ast) B <b>ingham</b>		Posey					Date of Deat Month 17Ch 24,		Year	3. Time of Death 7:43 A M
2000	/Medic Examin		4a. Facility Name (If not institution, Southern Maryland		mber)			Town, or L nton	ocation of	Death			ty of Death e Georg	ge's
# . # .	Funeral Director		5. Social Security Number 6 409–80–2063	Sex 1 ☐ M 242313€	7. Age (In yrs. 5		If Under Months	1 Year Days	If Under 24 Hours		Date of Birth (Month, Day,	1946	9. Birthi Cou	olace (State or Foreign ntry) Ohio
	a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince (	George's		y, Town or Lo per Marl								10d. Inside City Limits 1 ☐ Yes XXX No
	h with the	al Director	10e. Street and Number 9209 Live Oak Lar	ne			10f. Zip	Code 772			1	0g. Citizen o USA	f What Cou	ntry?
336	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23s or 28s-f show eumatic event, the Mudical Ezant art must be tridified at	by Funeral	11. Marital Status  1 Never Married XIXIXMarried 3 Widowed 4 Divorced	Armed F	2 NNo ve		Was Deced If Yes, spec I Pes	ofy Cuban	panic Origi Mexican, Specify:	in? (Specify Puerto Ric	y Yes or No- an, etc.)		ace - Ameri ack, White, ify: Whi	etc.
1215-0036	rithin 72 hounde. ne. han "nature e Mustical E	Completed	15. Decedent's (Specify only highest s Elementary/Secondary (0-12)	grade completed) College (		16a. Dece (Give life.	kind of wo DO NOT u	rk done du se retired)	ring most o	of working		16b. Kind of		
and 5	d fail	To Be Co	17. Father's Name (First, Middle, La Herbert Jonas	5 st) Bingham		Carmina				's Name <i>(F</i> Maxi	irst, Middle, I			<u> </u>
Maryland		Ĭ	19a. Informant's Name/Relationship William Posey / Hu	(Type, Print)			-		d Number		oute Number	, City or Tow		
	m O		20a. Method of Disposition  X⊠ Burial 2 □ Cremation 3	☐Removal from	State	Place of Dispo cemetery, crem	natory or o	ne of ther place,	,	Date		20c. Location	- City or T	own, State
Baltimore,	permit. Page Department of Important: If any injury or once.		4 □ Donation S □ Other (Spe 21. Signature of Funeral Service Lic		h : Res		2. Name an	d Address	of Facility	George	3, 2006 P. Kal Hill, M	as Fine	on, Mar ral Hon 20745	re PA
Ì	Physician		23a. Park. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition									est,		Approximate Interval Between Onset and Death
8760,	/Medical Examiner  bhysician and the burial-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	c. Chris	for as a consequence of the cons	1455 TA	Hy	pes,	Pins	lune		liseo		inknow v
O. Box 6	The law requires that the death certific ite has been signed by the attending p page 2 should be detached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	tcome of pregna birth 2 □ Feta nant at time of d lown	Il death 3	Ectopic pr Other (sp						ate of deliv	ery Day Year
rds, P.	quires that t in signed by uld be deta	þ	Part II. Other significant conditions	contributing to d	eath but not res	sulting in the u	nderlying c	ause giver	in Part I.			bacco use co	ntribute to t	he cause of death?
Il Records,		Completed									24a. Was a autops perform	Sy	Were auto prior to co death? 1 \( \sum \text{Yes}	opsy findings available impletion of cause of
Vita	Physicien: r this certificated director, i	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DC	Other	,		heck only on		that (Casal	4.1
Division of	ding Pt T. After th funeral	tion: To	27. Manne of Death  11 Natural 5 Pending 2 Accident investigat	28a. Date (Mor		28b. Time of Injury		8c. Injury a Work?	at	28d	. Describe ho			<b>y</b> /
Divis	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	Certification:	3 Suicide 6 Could no determine	286. Flaci	e of Injury - At hing, etc. (Specif		reet, factory	r, office		28f.	Location (St City or Town		nber or Rur	al Route Number,
	Hospi 24 hou Funer stely fill	edical	29a. Certifier 1 Certifying (Check only one)	Physician: To the barriner: On the barriner	e best of my kno pasis of examina iner stated.	owledge, deat ation and/or in	h occurred vestigation	at the time , in my opi	, date and nion, death	place, and occurred	due to the ca at the time, d	ause(s) and r ate and place	manner as s e, and due t	stated. o the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	20			290	. License	number		2	9d. Date sign	ned (Month,	Dey, Year)
)				Int			53	247	14		N	racel	1,2	5706
)	(5)		30. Name and address of person w	io completed cau	se of death (Iter	5 cul	3 -3	50	For	fwas	hat	in M	S ON	744
- PA 	Sta Registr		31. Date filed (Month, Day Year)	ns &	Registrar's Signa	ature	æ,				•			

سدور			1 - State Registrar		Ce	rtificate of L	Death	2. Date of De	Reg. No.	06	1347
	Physicia	an	Decedent's Name (First, Middle, Last					Month	Day	Year	3. Time of Death
	/Medic	al	Esther N. Proc			4b. Cily, Town, or	Location of Death	March 16		unty of Deat	4:52am M
			Washington Adventist	Hospital		Silver S	mim		Mont	anery	
F	uneral		5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h	9. Birt	hplace (State or Foreiguntry)
	irector		Usual Residence of Decedent	□ M 212 F	72 Yrs.		Tiours Wint.	April 7,			dad, West Ind
1215-0036 within 72 hours after death with the Maryland	how		10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
e Ma	in ream and manner rygains and analysis of terms 23s or 28s-1 show other traumatic event, it a Madical Examiner must be notified at	Funeral Director	MD Prince Ge	orges .	Capital H	eights					1 ☐ Yes 2 ☐ No
₹	or 28	ire	10e. Street and Number			10f. Zip Code			10g. Citizer	of What Co	untry?
₩.	23a	<u>ea</u>	1016 Jansen Avenue			20743			United	States	5
ф	"natural", or Items 23a adical Examiner must	ner	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spendardon Mexican Puerto	ecify Yes or No-	- 14.	Race - Ame Black, White	
affe	or the	F	1 Never Married 2 Married	1 ☐ Yes 2 🔯 N If Yes, Give		1 ☐ Yes 2 No	Specify:	Thours, oto.,			
Surs S	- E	1 by	3X Widowed 4 □ Divorced	Year or Dates:		10 165 22 140	Specify.		Sp	ecify: Bla	ick
ZIZID-UU30 ed within 72 hours aff	netu	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Dece	edent's Usual Occupa	ition Jurina most of work	ina	16b. Kind	of Business/	Industry
Z E	. S	힏	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	kind of work done of DO NOT use retired,	,				
N D 5	100	5	unknown		Hote	l Clerk			_Hotel		
be filed	vent vent	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Sui	mame)	
Maryland Z d 2 should be filed th and Mental Hvgi	rked IIC e	၉	Fitz Nelson				Beatrice St	eppherd			
z should	E E		19a. Informant's Name/Relationship (	Type, Print)	19b. Mail	ing Address (Street a	nd Number or Rura	al Route Numbe	er, City or To	wn, State, Z	tip Code)
	27 I		Esther Allette Da	ughter	1016	Jansen Avenu	e Capital H	eights, l	MD 207	43	
Desiring Pages 1 at Department of Hea	item 27 other tr		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other place	. [	Date	20c. Locat	ion - City or	Town, State
Pages	7 9 4		1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify			ln Cemetery	1	1/2006	Donahu	ccd, Ma	rul and
Demit. Pag	원금.	-	21. Signature of Funeral Service Licen		// //	2. Name and Addres					
Dentiit.	any once		Luane	5 616	NN/		Ju	n T. Rhi			me
				plications that caused		3015 12th St				20017	Approximate
		- 1	23a. Part1. Ent-the disease, or com- shock, or h-art failure. List only	one cause on each lin	10.	ter the mode or dying	, such as cardiac (	or respiratory at	1851,		Interval Between Onset and Death
	sician		Immediate Cause (Final disease or condition	a. Sepsis							6 weeks
	ledical		resulting in death)		a consequence of):						<u> </u>
EX	aminer		Sequentially list conditions	b. End Sta	ge Renal 1	Disease					years
T	-	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence of):						
te be executed	hysician and the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c							
S S	an ag	M	resulting in death) Last	Due to (or as a	a consequence of):						
te be ex	/sicia	cal		d							
g g	d d d										
The law requires that the death certifica	ed by the attending ph detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d	Date of deli	verv
eath D	for	clar	in the past 12 months?	1□Live birth 4□Pregnant at		☐Ectopic pregnancy ☐ Other (specify)				Month	Day Year
i ed	the ched	ysl	1 ☐ Yes 2 ☒No 9 ☐ Unknown	9□ Unknown							
hat i	ad by detac		Part II. Other significant conditions c	ontributing to death by	ut not resulting in the s	inderlying cause give	n in Part I	23e. Did to	obacco use	contribute to	the cause of death?
necolds, The law requires t	s been signed to should be det	Completed by	Diabetes	<b>-</b>					res 2√D√N		obabiy 4 □Unknowr
inbe	plnot	ted						101	es ACXIV		
a c	as be	ble	Cerebrovascular A	ccident				24a. Was	an 2	4b. Were au	topsy findings available completion of cause of
The	s certificate has b lirector, page 2 s	E						perfo	rmed?	death?	2 No
	infica for, p	0	25. Was case referred to medical				26. Place of Death	<u> </u>	· · · · ·		
OI VITALI Physician: T	director,	0 0	examiner? 1 ☐ Yes 2 🎛 No	Hospital: 1X Inpatie	nt 2 ER/Outpatie	nt 3 DOA Othe			*	Other (Sne	riful
	After this funeral di	-	27. Manner of Death	28a. Date of Injur	y 28b. Time o	of 28c. Injury	at	28d. Describe h			y/
LIVISION I or Attending	fun fun	후	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury	Work M 1□1	? ′es 2 □ No				
Attending redeath.	To the Funeral Director: After the completely filled in by the funeral	Certification:	3 ☐ Suicide 6 ☐ Could not be		ury - At home, farm, st			28f. Location (S	Street and N	umber or Ru	ral Route Number,
5 6 5	in b	Ĕ	4 Homicide determined	building, etc		root, ractory, cirico		City or Tox	m, State)		,
To the Hospital or A within 24 hours after	lled			1							
a Hosi	To the Funeral	Medical	(Check only 2 Medical Exan	ysician: To the best on tiner: On the basis of	examination and/or in	th occurred at the tim rvestigation, in my op	e, date and place, : inion, death occurr	and due to the c ed at the time, c	cause(s) and date and pla	d manner as ice, and due	stated, to the cause(s)
To the	the	led	one)	and manner sta	ted.						
-	5 00		29b. Signature and title of certifier	11-1.	Λ .	29c. License	number		_	•	n, Day, Year)
F .3			- Kalman	KUL	V	1)17	604		3.16	06	
7			- / Cood ac	/	-1		- 1	1			
7	6		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type	, Print)					
_ {	6)				eath (Item 23a) (Type cry Street		er, MD :	20712			

			For State Registrar	State of Ma	arylan		artment of H		nd Mental H	lygiene Reg. No.	06	11348
	Physici		1. Decedent's Name (First, Middle, I	Q UESEN	BER	RY			2. Date of Month	Day	Year 2006	3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution, g		] EN	TER	4b. City, Town, or BAL	Location of	Death		ty of Death	
	Funeral Director		219 28 8148	.Sex 7.Ag 1□M 2 <b>∑</b> F	9 (In yrs. 71	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of I	Birth Day, Year 2, 1934	9. Birth	place (State or Foreign ntry) Cyland
	show	7.	Usual Residence of Decedent  10a. State 10b. County			y, Town or Lo						10d. Inside City Limits 1 □XYes 2 □ No
	28a-f	recto	MD None  10e. Street and Number		Bal	timore	10f. Zip Code			10g. Citizen of	What Cou	
	3a or	Ö	1401 Forest Hill	Ave			212	230		United		-
	deatl	ner	11. Marilal Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13. \	Was Decedent of H	ispanic Origin	n? (Specify Yes or Puerto Rican, etc.)	No- 14. Ra	ace - Americ	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Itam 27 is marked other than "natural" or Itams 23a or 28a-f show styr injury or other traumatic avant. The Medical Examinar must be notified at anone.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		10		_	Specify:	dello Moan, etc.)	Spec	ack, White, <sup>ify:</sup> Whi	
2-0	"natu	Completed	15. Decedent's (Specify only highest (	Education grade completed)		(Give	lent's Usual Occupa	during most o	of working	16b. Kind of I	3usiness/In	ndustry
121	within then then	duic	Elementary/Secondary (0-12)	College (1-4or 5	+)		00 NOT use retired rator	)		Teleph	one (	Company
<b>J</b> d 2	other	BeC	17. Father's Name (First, Middle, La	st)	-	op.		18. Mother's	s Name (First, Midd			on.pon.y
ylar	Menta Menta arked aric so	To E	Charles Bealer					Mildre	ed Widerm	an		
Mar	12 sho h and 7 is m trsum		19a. Informant's Name/Relationship Thomas Bricker/E						or Rural Route Num llicott C			
e,	1 and Healt Ism 2		20a. Method of Disposition	xecutor	20b. P	lace of Dispo	sition (Name of		Date	20c. Location		
o E	Pages ent of nt: if It		1 Burial 23 Cremation 3 4 Donation 5 Other (Special Control of the		l		natory or other plac ematory		-30-2006	Catons	•	
Baltimore,	permit. Departm Imports sny inju		21. Signature of Funeral Service Lic	ionsee whi	M010	44 22 41	. Name and Addres	ss of Facility	Harry H. a Pike El	Witzke'	s Fam	uily FH Inc. MD 21043
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused by one cause on each lin	The death							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	_a.   12NS	) Un	100/1	4					Onset and Death
	/Medical Examiner		resulting in dealing	Due to (or as	a consequ	uence of):						
		ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a conseq	uence of):						
	icate be executed physician and s the burial-transit	Examiner	that initiated events	С								
8760,	be exe	aj Ex	resulting in death) Last	Due to (or as	a conseq	uence of):						
687	tificate ng phys as the	edical		d								
P.O. Box	death cei e attendir ed for use	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 MNo 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Feta	Ideath 3□	Ectopic pregnancy Other (specify)				ate of deliver	ery Day Year
rds, P	Se un eq	d by Pr	Part II. Other significant conditions	Contributing to death be AN EURYS	-	ulting in the u	nderlying cause give	en in Part I.		d tobacco use con		he cause of death? pably 4 Unknown
000	> 11 0	piete							24a. W		. Were auto	ppsy findings available
Œ E	The law cate has to page 2 s	Com			,				pe 1 ☐ Yes	topsy rformed? 2 1 10	death?	mpletion of cause of 2 □ No
Vita	Physicisn: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			l Othe	25	f Death (Check on)			
ŏ	Phys r this arai dii	7: 70	1 Yes 2 VNo 27. Manner of Death	28a. Dale of Inju (Month, Day		ER/Outpatien 28b. Time of	t 3 DOA Other	4 LI NUIS	ing Home 5 Re	esidence 6 Ot		(y)
ion	Attanding Phi or death. sctor: After thi by the funeral	ation	1 Accident 5 ☐ Pending investigat		(Year)	Injury		c? Yes 2∐No				
-	i or Attan after deatl Diractor: I in by the	Certification:	3 Suicide 6 Could not determine		ury - At ho	ome, farm, str	eet, factory, office		28f. Location City or 1	(Street and Num Town, State)	ber or Rura	al Route Number,
	To the Hospital or Attanwithin 24 hours after deatl To the Funeral Director:	edicai C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of aminer: On the basis of and manner sta	examina	wledge, death tion and/or inv	occurred at the time restigation, in my op	ne, date and pointion, death	place, and due to the occurred at the time	ne cause(s) and me, date and place	nanner as s , and due to	stated. o the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. License			29d. Date sign	ed (Month,	Day, Year)
			18	V	M	()	1)0	\$ 63	1430	MARCI	+ 26	2006
(ic	900		30. Name and address of person wh	o completed cause of d	eath (Item	3100	Daine					MD 21225
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 8	32. Registra			Couls,					

DHMH 17 Rev 1/2001

Registrar

MAR 28

2006

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year March Day Physician Ross 70:20 PM 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital 9. Birthplace (State or Foreign New York If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 □ M 2 X F Months Yrs. Director 85 August 27,1920 106-18-5785 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: if item 27 is marked other than "naturel", or itema 23 sor 28a-1 ehow 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or than "nature!", or itema 23a or 28a-f ehow 1 ☐ Yes 2√ No Maryland Montgomery Gaithersburg Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 382 Russell Avenue 20877 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: White 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+)  $5\pm$ Psychologist Psychology 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Norman Charles Goodwin Ethel Claudia Wheeler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Michael Ross/ Son P.O. Box 1123, Ellsworth, Maine 04605-1123 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State permit. Pages 1
Department of H
important: if ite
any injury and
once. Fort Lincoln Crematory 3/28/2006 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simple Tribute Funeral and 21. Signature of Figure eral Service Center, 1040 Rockville Pike, Rockville MD, 20852 23a. Part1. Enter the fisease, or complications that cause fine death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final Shock Septic 30045 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 8 days Infected Sheent Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760. Physician/Medicai use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Pressure Hydrocepholon Inknown Normal 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA this eral Director: After th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending death. 1 Tyes 2 □ No 2 Accident investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide To the Hospital o within 24 hours aff To the Funeral Di 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

12 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and it of certifier PAYST STAN y . Yastey 00063088 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 MID Kastogi, Mohit 9901 Medical Center Dr.; Rockville, MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 28 2006

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Physician LARA March 4:50 DM 26 2006 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sykesuille arroll BrINTON Woods NUISINGA Kenab If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 28, 7. Age (In yrs. last birthday) If Under 1 Vear Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Hours Months 1 □ M 2 1 F 78 Texas Director 464-36-6709 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Sykesville Carroll 1 ☐ Yes 2√ No Maryland Director al', or items 23a or 28a-f Examiner must be notified 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21784 5837 White Rock Road USA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status ☐ Yes 2 Yes, Give 1 Never Married 2 Married 2X No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: à Specify: white 3 ₩ Widowed 4 Divorced Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State Hospital Psychiatric Aide 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 1 end 2 should be Health and Mental Alyce Marie Williams Milam Sparks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 119 Mumper Lane, Dillsburg, PA 17019 Beverly A. Maus, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If Itel any Injury or ot once. 03730 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD Lake View Memorial Park 2006 22. Name and Address of Facility Wers-Durboraw Funeral Home ignature of Funeral Service Licensee MQ1191 91 Willis Street, Westminster, MD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) METASTATIC SMALL CIBL CARCINEMA OF LUNG > 1 Month /Medical Examiner Due to (or as a consequence of): Examine The law requires that the deeth certificate be executed ettending physicien and for use es the bunel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): ed by the e 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 D Unknown signed be de <u>ک</u> 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete has been si irector, page 2 should Completed 24 No 210 No 1 TYUS 1 🗆 Yes Attending Physician: director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ၉ 1 🗌 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation efter deeth.

Director: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify) filled in by 4 Homicide ö 24 hours e Hospital 1. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho To the Fune completely f To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number WJL March 29, 2006 unes

Registrar DHMH 16 Rev 6/95

10

State

RIBLEY,

It foods

SUITE 102;

32. Registrar's Signature

1000 LIBORTY

ELDERSBURG MD

and address of person who completed cause of death (Item 23e) (Type, Print)

2006

[URNCS

MAR 2

TATRICK

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician Violet E.Rawlings 26 3:35A Mar 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 703 A Cherrytown Rd. Westminster Carroll Birthplace (State or Foreign Country) If Under 1 Year II Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 F Director 215-54-2741 July 5,1901 104 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturet", or items 23s or 28s-f show other treumstic event, the Medical Examinat must be notified at 1 TYAS 2 XNo Director ΜĎ Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 703A Cherrytown Rd. 21158 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene Important: If Item 27 is marked other than "naturet", or Item eny injury or other treumatic event, the Medical Evantana Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates: Specify. 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) 8 Housework Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William D.Osborn ပ Mary Gayleard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Rawlings 20b. Place of Disposition (Name of cemetery, crematory or other place)

Rd. Westminster, MD 21158

20c. Location - City or Town, State Daughter 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Mar. 29, 2006 Finksburg, MD Evergreen Mem. Gardens 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Little; sFH 34 Maple Ave.Littlestown, PA17340 23a. Part1. Enter the disease, or complications that caused the deal shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ettending physicien end for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the e 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificete has funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Medical Certification: To 2 ER/Outpatient 3□ DOA (his 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death 2 Accident within 24 hours after deatl To the Funerel Director: 6 Could not be determined 3 ☐ Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of WIL person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

aiken

31. Date filed (Month, Day, Year)

10

with the Maryland

death v

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

or Attending Physicien:

To the Hospitel

Main

32. Registar's Signature

			1 - For State Registrar	State of Maryla	and / Depa			Mental Hygie	•	6	11353	)
-	· 28 ***	Į.	1. Decedent's Name (First, Middle, Last)					2. Date of Death	Day	Vane	3. Time of Deat	h
1	Physici /Medic		RICHARD	Α.	RILEY			Month MARCH	25 20	006	0213	М
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town,	or Location of Death		4c. County	of Death		
1			ATLANTIC GENERAL	HOSPITAL		B	ERLIN		WO	RCEST	ER	
	Funeral	=71.5	5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday)	If Under 1 Year Months Days		8. Date of Birth (Month, Day, NOV . 24,	(ear)	9. Birthp	lace (State or For	eign
	Director		Usual Residence of Decedent	/			110013	NOV. 24,	1933	MAH	RYLAND	
	hours after death with the Maryland turel', or Items 23a or 28e-f show at Exardinary wat by notified at	tor	10a. State 10b. County  MARYLAND WORCESTE		OCEAN					1	0d. Inside City Lin 1 X Yes 2 □	
	r 28e	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of V	/hat Cour	itry?	
	h with		13005 ANCHOR COU	RT			21842		US	A		
	ter deat Items 2	Funeral	11. Marital Status	2. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent of	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No-		e - Americ k, White,	an Indian,	
9	72 hours after des "natural", or Items ofcel Examiner "		1 Never Married 2 Married	1 X Yes 2 No If Yes, Give		1 ☐ Yes 2X No		rnoan, etc.,	Specify			
8	72 hours natural',	d by	3 ☐ Widowed 4 🖔 Divorced	Year or Dates: 19	54-56		- Coperation of the company of the c		Specify	WH	ITE	
5	72 na	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occu kind of work done	during most of work	ting 16	6b. Kind of Bu	siness/Ind	dustry	
2	d within piene. r than "	шb	Elementary/Secondary (0-12)	College (1-4or 5+)	1	DO NOT use retire ABLE SPL:	•		TELE	ономи	,	
2	D 0 = -		17. Father's Name (First, Middle, Last)		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ADLE SEL.		e (First, Middle, Ma			2	
E C	ed at a be	Be		DII	77						CON	
3	Men Marke Marke	2	JAMES D.	RILE		4.4.	WILSIE			JACK		
Maryland 21215-0036	d 2 should th and Mer 7 Is marke traumatic		19a. Informant's Name/Relationship (Typ	· ,			t and Number or Run			State, ZIP	C008)	
	1 and Health Sm 27 ther to		LYNNE BARTON/DAUGH 20a. Method of Disposition		o. Place of Dispo	The second secon	BERLIN, M		oc. Location -	City or To	wn State	
و	Pages 1 an nent of Heal ant: If Item 2 ary or other		1 🕅 Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, crei	natory or other pla	100)	_		•		A BITT
ţ	그 두 후 등		4 Donation 5 Other (Specify)			EM CEMETI		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	PARSON	SDUKG	G, MARYLA	ML
Baltimore,	Depar Impor any Ir		21. Signature 1 Funeral Service License	WA T		Name and Addr ASTINGS	ess of Facility FUNERAL HO	ME, SELB	YVILLE	, DE.	19975	
	Physician /Medical Examiner	ner	23a. Paint Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	AC UV	·	blodels				Approximate Interval Between Onset and Death  3 March 1	
8760,	sate be executed only sician and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):							
P.O. Box 68	that the death certificate be exected by the attending physician detached for use as the buria	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3[	]Ectopic pregnand ] Other (specify)	су		23d. Dat Moi	e of delive	ery Day Year	
	The law requires that the ate has been signed by the bage 2 should be detache	by P	Part II. Other significant conditions cont	ributing to death but not	resulting in the u	nderlying cause g	ven in Part I.	23e. Did toba	icco use conti	ribute to th	ne cause of death	?
ğ	quires in sign uld be	pe p	NONE					1 🗀 Yes	2 □ No	3 🗌 Prob	ably 4 0 Unknown	own
Vital Records,	w requir s been si should I	ompleted						24a. Was an			psy findings avail	
æ	The lavate has	mc d						autopsy	ed? c	leath?	mpletion of cause	of
a		Ö	25. Was case referred to medical				26 Place of Deat	th (Check only one		Yes	2X No	-
5	Physicien: this certific	0 8	examiner?	spital:	ER/Outpatier	nt 3 DOA O	hor	ome 5 Residen		er (Specifi	v)	
ō		12	27. Manner of Death	28a. Date of Injury	28b. Time o	28c. Inju	ıry at	28d. Describe how				
0	Attending ir death. ector: After by the fune	i i	1 Natural 5 Pending 2 Accident Investigation	(Month, Day Year	r) Injury		ork? ]Yes 2 □No					
Division of	or Attence after death Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp.	t home, farm, strecify)	reet, factory, office		28f. Location (Stre City or Town,		er or Rura	l Route Number,	
	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	edical C	29a. Certifier 1 Certifying Physical (Check only one) 2 Medical Examin	cian: To the best of my er: On the basis of exam and manner stated.	knowledge, deat rination and/or in	h occurred at the t vestigation, in my	ime, date and place, opinion, death occur	and due to the cau red at the time, dat	use(s) and ma e and place, a	nner as s	tated. the cause(s)	
	To the within To the COMP	M	29b. Signature and title of certifier		c 1 1 17		se number		d. Date igned	d (Mo h,	Day, Year)	
	08		Horn	7 My HO	sp, talus	DOC	50826		3/2	5/0	6	
1	18,6		30. Name and a s of person who cor	npleted cause of death (	Item 23a) (Type,					fi.		
(	1 17,		PAZAAK ENI	OLA 4	733 H	Ealth v	say Dr	BRUN	MD	21	811	
	Sta	te	31. Date filed (Month, Day, Year) MAR 2 8 201	32. Digistrar's Si	gnature							

11-24-33

0000

214-32-6557

Richard Riley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | 6 Certificate of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) 3. Time of Death Year Physician 2034 Dorothy 2006 Jester Reed March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death Union Hospital E1kton If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 TE Yrs Director 222-16-6220 76 March 19,1930 Wilmington, DE Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Worle If item 27 is marked other than "natural", or itema 23a or 28a-f show or other traumatic event, it a Madical Exeminan must be collined at 1 Yes 2 No Director MD Cecil **Elkton** 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? **USA** Completed by Funeral 3 Chesapeake Elderly Apts. 21921 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 2 No Maryland 21215-0036 1 Yes 2K No Specify. Specify: white 3 Widowed 4 Divorced al Hygiene. other than "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be le marked o Pages 1 and 2 should be Eugene Hale Elizabeth M. Kaiser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Depertment of Health a Important: If item 27 le any injury or other trangue. Barbara A. Turner (daughter) 105 W. Monroe Ave. New Castle, DE 19720 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 □Removat from State 4 ☐ Donation 5 ☐ Other (Specify) Gracelawn Mem. Park | March 29,2006 New Castle, DE 21. Signature of Fun al 22. Name and Address of Facility McCrery Funeral Homes, Inc. 3924 Concord Pike Wilmington, DE enter the mode of dying, such as cardiac or respiratory arrest. 19803 mate 23a. Part I. Enter the disease, of complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit a physicien and P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Ao

9 Unknown Year page 2 should be detached for Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 3 Probably 4 Unknown 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has 1 Yes ZONO 1 Yes in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 ☐ Yes No Other: 4 Nursing Home 5 Residence 6 Other (Specify) In atient Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of After 5 Pending investigation Naural 2 ☐ Accident 1 ☐ Yes 2 ☐ No M within 24 hours efter death. To the Funeral Director: A 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completely filled Certifying Physician: Tu the Sest of my knowledge, death consider the time, date and place, and due to the neuse(s) and menner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Daly signed (Month, Day, Year)

State Registrar 31. Date filed (Mgnth, Day, Year)

0 MAR 2 9

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

00063720

118 Neeth Street ste3B Elklon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State RegistraMEND#1percoveringMD3/28/06,BW,MccoCertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) SCHLEGEL 2 Date of Death ANITA 3. Time of Death Day Month Yea. **Physician** 206 7:00 AM 26 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Mary land Baltmore University medica 1 Conk If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 37 5. Social Security Number Birthplace (State or Foreign
Country) 6 Sax 7. Age (In yrs. last birthday) **Funeral** Days Hours Min New York 1 M 2 F 69 Director 078-30-6551 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location th and Mental Hygiene. ?7 is marked other than "natural", or itame 23s or 28s-1 shov treumstic event, it a Medical Exaction must be notified at Maryland Howard Glenwood 1 Yes 2 No Director the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14516 MacClintock Court 21738 United States by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married White Baltimore, Maryland 21215-0036 1□Yes 2XNo Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education 16a, Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1-4 Office Manager Property Management 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If frem 27 is marked oth any injury or other treumatic avent 9DEs: Be Jewell Rittenhouse Janette Fitz Randolph Harlev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14516 MacClintock Court Glenwood, Maryland 21738 Walter H. Schlegel -husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slate 20a, Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Carmel United Methodist Church Cemetery 4/1/2006 Sunshine, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part1. Enler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death CALLAR ( TO DO C. SOMETER OF MEDICAL SOMETER Immediate Cause (Final hor B Physician disease or condition resulting in death) Dolural /Medical Due to (or as a consequence of); Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No P.O. 9 Unknown 9 Unknown been signed by i should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has throm bosis 2 No this certificate 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending fall at death. 4:40A 1 ☐ Yes 2 ☑No investigation 25,2006 2 Accident home Director: A 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 14516 Hac Chintock Ct Glenwood MD 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide or A Home enwood To the Hospital within 24 hours a To the Funeral E 29a, Certifie 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 16536 10 ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who dome Greene St. Baltimore, MD 21201

State

Registrar

31. Date filed (Month, Day, Year)

MAR 28

2006

# I America & Busher 3 & my Vetas 14 floring 100 Bred. Ender with

MD

othling

32 Registrar's Signature

			1 - For Stata Registrar			Marylar		artment of H tificate of L		nd M		Reg. No.		11356
	Physici	ian	Decedent's Name (First, A		•	_					2. Date of De Month	Day	Year	3. Time of Death
	/Medi	cal	Robert		ee		chuber		Jr.		Marc		1006	17:50 M
1	Examir	ner	4a. Facility Name (If not instit	11	1 /	oer) I	1 1	4b. City, Town, or	- 4	Death	21	4 4 4	ty of Death	
	Funeral		SACRED 5. Social Security Number	6. Se	AR+ H	05 \$1.7 . Age (In yrs.	last birthday)	If Under 1 Year	ff Under 2		8. Date of Bir	ALL	9. Birth	place (State or Foreig
D	Director		216-38-1209		XM 2□F	64	Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da Sep 5	, 1941	Cou	Ю́Н
	DE .		Usual Residence of Deceder											
	anyla ehov	2	MD 10b. Co	ınıy Ilegar	ıv.	10c. Ci	ty, Town or Lo	berland						10d. Inside City Limits
	Ba-f	ecto		licgai	'y									1 X Yes 2 No
	72 hours aftar daath with tha Maryland natural', or iteme 23a or 28a-1 ehow dissal Evarshrat te motified at	Funeral Director	10e. Street and Number	lon/o	Λνοπιο			10f. Zip Code	21502	,		10g. Citizen o	JSA	intry?
	aath	eral	709 1/2 St. N	iai y S	12. Was Deced	ent Ever in II	IS 13 1				city Yes or No		ace - Ameri	can Indian
	ftard	Fun	1 Never Married 2	Married	Armed Ford	es? :□No		Was Decedent of Hi 1 Yes, specify Cuba	n, Mexican,	Puerto I	Rican, etc.)	BI	ack, White	
936	urs a	b	3 ☐ Widowed 4 🌠 Divo	rced	If Yes, Give Year or Dat	es: 1960	-66	1□Yes 2ŽNo	Specify:			Spec	ify: whi	te
21215-0036	72 ho	Completed	15. Dec	dent's Edu	cation	7 6	16a. Deced	ient's Usual Occupa	ation	of worki	na	16b. Kind of	Business/Ir	ndustry
2	within ana. than "	nple	Elementary/Secondary (0-		Colfege (1-4	for 5+)	life.	DO NOT use retired	)	OI WOTKI	19 1			
	led w lygiar her th		12 17. Father's Name (First, Mic	tito ( a sh)			salesr	nan	40. 14-11-1	4 11	(F) . 14: / II	Sears		
anc	ntal H	Be	Robert L.		ort Sr							Schube	,	
Maryland	should be filed withir and Mantal Hygiana. s marked other than sumatic event, the Ms	To	19a. Informant's Name/Refa				10b Mailir	ng Address (Street a						a Codol
Ma	nd 2 sho alth and 27 is ma ir trauma		Sherri Schub			ughter		John Stree		O/ / ID/ B	New		N'	
ē,	s 1 and 2 should be filed within 72 hours aftar daath with tha Marylan f Haalth and Mantal Hygiana. Item 27 is marked other than "natural", or iteme 23s or 28s-1 show other traumatic event, Ite Medical Exercit as trained to notified at		20a. Method of Disposition			20b. F	Place of Dispo	sition (Name of	- 1	D	ate	20c. Location	- City or T	own, State
JUO	Pagas nant of I int: If its iry or o		1 ☐ Burial 2 ☐ Xemail					natory or other plac ineral Home			4/2/2006	Cresa	wota	n MD
Baltimore,	그 든 뿐 글 .		21. Signature of Funeral Ser			/// 5		. Name and Addres Scarpel		-111-	DA	0.000		
ä	Dapa Impo any in		►//I(/I////	17	MI	M						rland, MI	1 2150°	2
			23a. Part1 Enter the diseas shock, or heart failure.	e, or comp	ications that can	sed the deat	h. Do not ent	er the mode of dying	g, such as c	ardiac o	r respiratory a	rrest,	2 2 100	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	List offiy o	H	uto	5 M	IMPONI	me.O	V	1.18	tun		Onset and Death
1	/Medical		resulting in death)	-	a. Due to (o	r as a conseq	uence of): /	90-au	<i>3-</i> 44	1	yaru	ve	+	011160
в	Examiner		Sequentially list conditions		b		V			1				
	ש ש	ner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	,	Due to (or	ras a conseq	juence of):							
	cata ba axacutad bhysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	c							· · · · · · · · · · · · · · · · · · ·		
8760,	oa ax cian a ourial	Ū	resoluting in doubly least		Due to (or	ras a conseq	juence of):							
87	physi the t	dlcai		•	d									
9 X	Attending Physician: The law requires that the death cartificate be axecuted rideath. rideath. ector: After this cartificate has been signed by the attending physician and by the timeral director, page 2 should be deteched for use as the burial-transit.	Physiclan/Med	IF FEMALE:		23c. If yes, outco	ome of preana	ancv					224 5	ata at data	
Вох	attan attan for u	clan	23b. Was decedent pregnan in the past 12 months?		1 Live birt	h 2∐Feta ntattime of d	ıl death 3 ☐	Ectopic pregnancy Other (specify)					ate of defiv Ionth	Day Year
P.O.	tha d y tha iched	ıysi	1 □ Yes 2 □ No 9 □ Unknown		9□ Unknow			- Cinor (apoony)						
٣.	that adb	y P	Part If. Other significent cor	ditions co	ntributing to dea	th but not res	ulting in the u	nderlying cause give	en in Part I.		23e. Did t	obacco use co	ntribute to I	he cause of death?
rds	quira; n sig uld bu	d b	Chylonic	14	M di	5845e					10	Yes 2 □ No	3 🗆 Pro	bably 4 Hunknown
00	sw raquire s baen sig s should b	ojet		0							24a. Was		. Were auto	opsy findings available
of Vital Records,	Tha lay ta has aga 2	Completed by									autor perfo	rmed?	prior to co death? 1  Yes	mpletion of cause of
ta	ician: Th cartificata ractor, pag	a	25. Was case referred to me	dical		/			26. Place	of Death	(Check only o		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2L NO
<b>&gt;</b>	Physici this ca al dirac	To B	examiner? 1 ☐ Yes 2 ☑ No	Ī	Hospital: 1 Ing	patient 2	ER/Outpatien	t 3□ DOA Othe	25			dence 6 🗆 O	ther (Speci	fy)
0	ng Pt Iter th naraí	ü	27. Manner of Death 1 ■ Natural 5 □ Pe	ndina	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	28c. Injury Work	at	2	8d. Describe	now injury occi	ırred	
<u>Ö</u>	uttendin daath. ctor: Afi y tha fur	atle	2 Accident in	estigation uld not be					Yes 2□N	0				
Division	or Att	Certification:		termined	28e. Place o	f Injury - At h j, etc. <i>(Specil</i>	ome, farm, str (y)	eet, factory, office		2	28f. Location ( City or To	Street and Nun vn. State)	nber or Run	al Route Number,
	To the Hospital or Attending Physician: Tha I within 24 hours after daath.  To the Funaral Director: After this cartificata ha complataly fillad in by tha funaral diractor, paga													
	Hosi 24 ho Fund Italy f	Medical	29a. Certifier 1 Cert (Check only 2 Med	itying Phy ical Exami	inar: On the bas and manne	is of examina	owledge, death ition and/or inv	occurred at the time vestigation, in my op-	ie, date and pinion, death	place, a occurre	and due to the ad at the time,	cause(s) and r date and place	nanner as s , and due t	stated. o the cause(s)
	ithin the or the	Mec	29b. Signature and title of ce	ntifign /	and marine	r stated.		29c. License	number			29d. Date sign	ed (Month.	Dev. Year)
	10		•	4/1	1/2000	a I M	0	r		210	7	_		3,2006
	10		30. Name and address of pe	son who o	ompleted cause	of death /lter	n 23a) (Tune	Print)			•			
	nRs		DR. Gary h	agan	er/925	Bish	op Wals	st Road	Cur	ber	LavD,	MD 2	150	2
30	Sta	ite	31. Date filed (Month, Day, )	ear)	32.	sintrada Cisa								
Ŕ	Registr		MAR 3	1 200	6	Erre 1	S A	all .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | | | 1 - For State Registrer Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 2006 Thomas Elwood Skidmore
4a. Fecility Name (If not institution, give street and /Medical number) 4b. City. Town, or Location of Death 4c. County of Death Examiner If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min Months Hours 1 M 2□ F Yrs. Director 218-50-0302 Usual Residence of Decedent 07-Apr-1945 Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f show 10c. City, Town or Location 10d. inside City Limits 10b. County 10a State other traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No Directo Maryland LaVale Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Roger Way U.S.A. 14. Race - American Indian, Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 € No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) assistant manager
18. Mother's Name (First, Middle, Maiden Sumame) dry cleaners 17. Father's Name (First, Middle, Last) Be ၉ Leona Ann Skidmore unknown 19a. Informant's Name/Relationship (Type, Print) nber or Rural Route Number, City or Town, State, Zip Code) 11505 Rollville Road 21545 William Skidmore brother Mount Savage Maryland 215
Date 20c. Location - City or Town, State 20b. Pface of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State injury 4 ☐ Donation 5 ☐ Other (Specify) Frostburg Memorial Park 25-Mar-2006 Frostburg Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility 2 Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Approximate Interval Between Onset and Death Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or flock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical days Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use/contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 26. Place of Death (Check only one Be 25. Was case referred to medical examiner? Hospital: Other: 1 Inpatient 1 ☐ Yes 2 No 2 ER/Outpetient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Naturaf 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

10 nLs

DHMH 17 Rev 1/2001

State Registrar

(Check only one)

31. Date

29b. Signature and title of cert

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

				State of	Marylan		artment o			and M	lental Hy	giene	06		1358
	Physici	an	1. Decedent's Name (First, Middle, La	•							2. Date of Dee		Year		ne of Death
,	/Media	cal	Alice Tobatha Sm						- Oh. Tau		March		2006		:59 PM
1	Examir	ner	4a. Facility Name (If not institution, given Beverly Health C		iber)				Hager		ocation of Death WN		y of Death shing		
	Funeral		Social Security Number 6. 5	Sex	7. Age (In yrs. I	ast birthday)	If Under 1	rear	If Under 2	24 Hrs.	8. Date of Birt (Month, Day				tate or Foreign
	Director		217 20 1747	□M 2X0F	94	Yrs.	Months D	ays	Hours	Min.	09/13/	1911	Cou	ntry)	WV
	and and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Insid	de City Limits
	Mary t-f eho	ţō	MD Washin	gton	I	Hagers	town								Yes 2□No
	or 286	Sirec	10e. Street and Number				10f. Zip Co					10g. Citizen of		ntry?	
	ath w	Funeral Director	750 Dual Highway				217					US			
_	ter de Items	-une	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Deced Armed For 1  Yes		5. 13. V	Vas Decedent f Yes, specify	t of His Cubar	spanic Orig n, Mexican,	in? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14. Ra	ce - Ameri ick, White,		ın,
020	ursaf al', or Eram		3X Widowed 4 Divorced	If Yes, Give Year or Da	9	1	I□Yes 2√∑	l No	Specify:			Speci	fy: Wi	nite	
2 0	72 ho 'natur dical	Completed by	15. Decedent's Ed (Specify only highest gra	ducation de co <i>mpleted</i> )		(Give	lent's Usual O kind of work o	tone di	urina most	of worki	ing	16b. Kind of E	lusiness/In	dustry	
121	within	dm	Elementary/Secondary (0-12)	College (1-	4or 5+)	life. L	oo wot use n Clerk	etired)					Retai	: 7	
2	Hygie other ent, II	Be Co	17. Father's Name (First, Middle, Last,				CIEIK		18. Mother	r's Name	(First, Middle,			L.L	
/lan	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f ehow eumatic event, the Medical Examiner mast be righted at	To B	James William Ki	rby						E11a	a France	es Wils	on		
_	D = N =	. 5	19a. Informant's Name/Relationship ( Margaret Disimon	Type, Print) e/Grando	laughtr	19b. Mailin 710 S	g Address (S Char	treet a. 1es	nd Numbei St.,	r or Rura Ba.	l Route Numbe ltimore	r, City or Town	, State, Zij 230	Code)	
baitimore,	es 1 an of Heall fitem 2 r other		20a. Method of Disposition	Domeus from C	CO	ace of Dispos metery, cren	sition (Name o	of r place	)		Date	20c. Location	- City or To	own, Stat	te
Ĕ	. Pages tment of tant: If its jury or o		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		St 1		Luther					Wolfsvi			
n D	permit. Pages Department of Important: If it eny injury or c		21. Signature of Eunoral Service Licer	si)e	$\mathcal{O}$						rald N.				
			23a Parti Enter the disease or som	plications that as	used the deeth						eet, Ha		n, M		
	Physician	0 9	23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on ea	ch line.	. Do not ente	ar the mode of	i dyllig	, such as c	ardiac o	respiratory an	1031,	1	Interval Onset	imate I Between and Death
	/Medical		Immediate Cause (Final disease or condition	. Ta	Telen	L I	= 1t	Lγ	ive.	,	more		1	37	unun
	Examiner	<u></u>	resulting in death)		Due to (or	as e conseq	uence of):	_					1	2	unui virilla
	uted d ansit	Examine		b	euwen			uti	cu (	ne	more	-0		3ne	irlle
Ď.	an and	Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		Due to (or	as a consequ	uence or):								
0/0	icete be executed physician and s the bunal-transit	dlcal	that initiated events resulting in death) Last	C	Due to (or	as a consequ	ience of):						- 1		
ם XO	certificate be executed adding physician and use as the bunal-transit	<b>o</b>		d											
6	death d for u	iciar	Part II. Other significant conditions or	ontributing to dea	th but not resul	ting in the un	derlying caus	e aiver	n in Part I		23h Didte	obacco use co	intribute to	o the car	see of death?
5	d by the	Physician/M		The state of the s			acting the care	o givo				′es 2□No			1
cords,	signe d be c	d by	West Control of the C								24a. Was a	a autonov	24h W	ere autor	osy findings
3	w requ	Completed									perfor	med?	av	ailable pr	
֡֝֟֝֟֝֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֡֓֡֡֝	he lay te has age 2	ошо									1 🗆 Y	es 20XNo			2√2 No
<u> </u>	ien: artifica ctor, p	Be	25. Was case referred to medical examiner?						26. Place	of Death	(Check only or		1		N
5 ;	hysic this ce al dire	P	1 ☐ Yes 2 ☑ No 27. Manner of Seth	Hospital:		R/Outpatient		Other	4AQ Nurs		ne 5□Reside			y)	
	ath. r: After ne funer	ation	1X Natural 5 ☐ Pending 2 ☐ Accident investigation		Day Year)	28b. Time of Injury		Injury a Work? 1 ☐ Ye	es 2 □ N		Red. Describe h	ow injury occur	rea		
	J or Atter de after de Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	286. Place o	f Injury - At hon g, etc. <i>(Specify)</i>	ne, farm, stre	et, factory, off	fice		2	28f. Location (Si City or Town	treet and Numl n, State)	er or Rura	l Route I	Vumber,
		edical C	29a. Certifier (Check only one)												se(s)
	ro the within To the compli	₹ 	29b. Signature and title of certifier	î &1, -	1		29c. Lic	cense	number	1:-	extron	9d. Date signe	d (Month,	Day, Yea	i <i>r</i> )
			Mayen 3	Jona	p			D	285	07		5-18	-06 -		
			30. Name and address of person who of BNGN2AV.	completed cause	of death (Item :	23a) (Type, F	Print) Chr	016	- N	ao	exton	w mo	217	40	
	Stat	te	31. Date filed (Month, Day, Year)	32. <b>M</b>	gistrar's Signatu	ire /	م المو	- 4		0		. 0			
	Registra		MAR 29 21	106	and hi	1. 130	extend								

DHMH 16 Rev 6/95

			1 - For State Registrar	State of Maryland		artment of H			giene Reg. No.	006	1359
	7		Decedent's Name (First, Middle, Last)	)		· · · · · · · · · · · · · · · · · · ·	<del></del>	2. Date of De	ath		3. Time of Death
1	Physici		Carl David Smith					March	Day	ADC	1.0
	/Medic Examin	4	4a. Facility Name (If поt institution, give			4b. City, Town, or	Location of Dea		4c. (	County of Dea	
		10 de	Washington County	Hospital		Hagersto	own		M	shina	ton
7.7	Funeral		5. Social Security Number 6. Se:	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		h	9. Bi	rthplace (State or Foreign Country)
有野	Director		214-09-2507	<sup>3M 2□ F</sup> 91	Yrs.			Jan. 1			
	pus *		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Lo	cation					10d. fnside City Limits
	l sho	5									1 ☐ Yes 2 ☑ No
	28a-i	Directo	Maryland Washingto  10e. Street and Number	n Hager	'STOW	n 10f. Zip Code			10a Citiz	en of What C	Country?
	with a or	ā	11035 Rosewood Dri	VA		21740			USA		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	death with the Maryland ma 23a or 28a-f show	Funeral		12. Was Decedent Ever in U.S.	13, V	Was Decedent of H	ispanic Origin? (	Specify Yes or No			nerican Indian,
	riter	Fur	1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 XYes 2 No 1944	-	f Yes, specify Cuba		rto Rican, etc.)		Black, Wh	ite, etc.
m O	hours after turei', or ite	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates: 1946	5   1	1 ☐ Yes 2 ☑ No	Specify:			Specify:	White
S O	be filed within 72 hours after death with the Marylan tal Hygiene.  at thy giene.  at the Macleal Examiner must be notified at event, the Macleal Examiner must be notified at	Completed	15. Decedent's Edu (Specify only highest grad		6a. Deced	dent's Usual Occup	ation	orkina	16b. Kin	d of Busines	s/Industry
2	filed within 72 Hygiene. Hyer then "nel	npie	Elementary/Secondary (0-12)	Coflege (1-4or 5+)	life. L	DO NOT use retired	) -	oming.			
2	ygier ygier tt, th		7	0 1	lach i	ne Operat		- (=)			Manufacturer
Ē	tai H d oth	Be	17. Father's Name (First, Middle, Last)					ame (First, Middle,	Maiden	Sumame)	
<u> </u>	should be and Mental a marked o umatic eve	To	George W. Smith	0:4			Winnie				7.0.44
Maryland 21215-0036	2 2 2	11	19a. Informant's Name/Relationship (Ty			ng Address (Street a					21740
	1 an Heall em 2 ther		Gladys V. Smith (W					Date		·	or Town, State
Baltimore,	of I		1 ⊠Buriai 2 ☐ Cremation 3 ☐ F	idilioval ilolli State		sition (Name of natory or other place	I	7 0006		-	
٥	permit. Page Department i Important: If any injury or once.		4 Donation 5 Other (Specify) 21. Signature of Puneral Service License	4		n Mem. Pa		7-2006	WIII	Tamspo	ort, Maryland
e R	Dep Perm				_			ome P.A.	425	S. Con	ococheague
п	7		23a. Part1. Enter the disease, or complessiock, or heart failure. List only or	ications that caused the death. [	Do not ente	<ul> <li>Willia</li> <li>er the mode of dyin</li> </ul>	<b>msport,</b> g, such as cardia	Mary Land ac or respiratory ai	21	795	Approximate
ı.	Disconicion		shock, or heart failure. List only or fmmediate Cause (Final	ne cause on each line.	1-1	1 1	01	,	A.		fntervaf Between Onset and Death
34. T.	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequen	NSQX	ucdine	ILLMO	rary du	Sedo	-	36×
	Examiner			Chronic Re	1011	Fay Ding		0			CY
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequen	ce of):						3/
	cuted	Examiner	that initiated events	D							
Ď,	e exe lian a urial-l	ΕX	resulting in death) Last	Due to (or as a consequen	ce of):						
8760	cata be executed bhysician and the burial-transit	dicai		d							
9	eath certific attending p	/Mec	IF FEMALE:	3c. If yes, outcome of pregnancy							
Box	attend attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fetaf de 4 Pregnant at time of death	ath 3	Ectopic pregnancy			2	3d. Date of de Month	elivery Day Year
o	at the de by the stached	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	1 3	Other (specify)					
J.	res that igned by be deta	Y.P.	Part II. Other significant conditions cor	ntributing to death but not resulting	ng in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco us	se contribute	to the cause of death?
Records,	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	d by						10	es 2	No 35	Probably 4 Unknown
Ö	w require been signature should b	Completed						24a. Was	an	24b. Were a	autopsy findings available completion of cause of
	rsician: The law s certificate has b lirector, page 2 s	шo							med?	death?	'
Vita	an: tifical tor. p	0	25. Was case referred to medical				26 Pface of D	1 ☐ Yes eath (Check only o	20 <b>X</b> No	1 1 10	es 2 No
≥	ysici is cer direc	To B	examiner?	lospitaf: 1 Inpatient 2 ER	/Outpatien	t 3 DOA Oth	or:	Home 5 ☐ Resid		□Other (Sp	ecify)
Division of	ding Phys h. After this funeral di	L.	27. Manner of Death 1 □ Altural 5 □ Pending	28a. Date of Injury (Month, Day Year)	b. Time of	28c. Injun Worl		28d. Describe I			
<u> </u>	andir oath. or: Af	atic	2 Accident investigation		,		Yes 2 □No				
Ĕ	or Attanctor ter death irector:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury · At home building, etc. (Specify)	, farm, str	eet, factory, office		28f. Location (S City or Tox	Street and vn. State)	Number or F	Rural Route Number,
	urs af		The state of the s		The State						
	To the Hospital or Attanding Physician: within 24 hours after dear M. To the Funeral Director After this certifica completely filled in by the funeral director.	Medicai	(Check only one)	ner: On the bast of my knowle	and/or inv	contumed at the tin vestigation, in my o	ne, date and plat pinion, death occ	curred at the time,	date and	and manner a place, and du	ue etated: ue to the cause(s)
	ithin 2 the o the omple	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licenso	number		29d. Date	signed (Mor	nth, Day, Year)
)	+ 3 ÷ 8		No				7232	_	3/	16/	
			30. Name and address of person who co	ompleted cause of death /ftem 33	la) (Tune				- (	316	
خ	H3+1		D. Wasien	32. Registrar's Signature	Pal	Cont	1.4	1 - Mid	. 2	174	7
14-20	Sta	te	31. Date filed (Month, Day Year)	32. Registrar's Signature	-	1	1	1			
	Registr	ar	MAK 16	2000 Been	J. 1	person					

			Please I	State of Mar						•	_		
		•	For State Registrar	State of Ivial	ylariu		tificate of		ALIGI MICI		2006	1360	
\$	36		1. Decedent's Name (First, Middle, Last)  2. Date of Death  3. Time of Death									3. Time of Death	
	Physicia /Medic		Tracy Lynn Bailey Shaffer				march				23,2006 12:01 M		
A.	Examin	I	4a. Facility Name (If not institution, give street and number)				4b. City, Town, or Location of Death				4c. County of Death		
	- Conservat	4	Washington County Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)				Hagerstown  If Under 1 Year If Under 24 Hrs. 8. Date of Birth				Washington 9. Birthplace (State or Foreign		
	Funeral Director			M 2 <b>∑</b> F	43	Yrs.	Months Days	Hours	Min. De	(Month, Day, )	1962 M	Country) aryland	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If them 27 is marked other than "natural", or itema 23a or 28a-1 show any injury or other traumatic event. It a Madical Examinar must be notified at once.	Director	Usual Residence of Decedent  10a, State 10b, County		10c. City, 7	Fown or Lo	cation					10d. Inside City Limits	
			Maryland Washingt		-		ville					1 <b>X</b> Yes 2 ☐ No	
			10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?							Country?			
		raiD	13926 Weaver Avenue				21767				USA		
		Funerai	11. Marital Status  1 Never Married 2X Married	2. Was Decedent Ev Armed Forces?	es 2 🔼 No , Give		Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 No Specify:			Yes or No- an, etc.)			
036		by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Oates:							Specify: White		
21215-0036		Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		(Give	dent's Usual Occup	during mos	t of working	10	6b. Kind of Busine	ess/Industry	
121		mple	Elementary/Secondary (0-12)	College (1-4or 5+	+) Process Analys			d)				Banking	
d 2		0	17. Father's Name (First, Middle, Last)		18. Mother's Name (First, Middle				irst, Middle, Ma	<u> </u>			
lan		To B	Donald L. Hays				Barbara L. Ward						
Maryland			19a. Informant's Name/Relationship (Typ		77	19b. Maili	ng Address (Street	and Number	er or Rural Ro	oute Number,	City or Town, Stat	te, Zip Code)	
			Robert J. Shaffe 20a Method of Disposition	r/Husband			Weaver		e, Mau		11e,Md。 Oc. Location - City	21767	
Baltimore,			1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	i		esition (Name of matory or other place en Cemete	1	3/28/			m, Maryland	
altir			21. Signature of Funeral Service License	е	Kest		2. Name and Addre					-	
Ö			> S. Mark Sin	m		1	601 Penns	sy1var	nia Ave	enue, H	agerstow	m Md 21742	
Ž.			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death										
X	Physician /Medical Examiner e parial-transit	ner	Immediate Cause (Final disease or condition a end-SMGE Colon cuncer with MRIS										
				Due to (or as a consequence of):									
*			Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or as a consequence of):									
		Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (dr as a consequence of):									
760,		cai E		Cantidenia									
68	h certificate ending phys use as the	edic											
Вох	or Attending Physicien: The law requires that the deat sifer death. Director: Atter this certificate has been signed by the atte in by the funeral director, page 2 should be detached for	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 mophs?	3c. If yes, outcome of pregnancy 1					23d. Date of delivery  Month Day Year				
		/ Physician/Medi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown										
P.O.											e to the cause of death?		
rds		ed by	emerococcal	(NFection 10)				Yes 2 0 3 Probably 4 Unknown					
eco		Completed	Tensian precurotherax					24a. Was an autopsy				24b. Were autopsy findings available prior to completion of cause of	
<u> </u>		Соп	25. Was cabe referred to medical 26. Place of Death (Check only one)										
Vita		o Be									Constil		
of		<b>—</b>	1 ☐ Yes 2 ☑ No 1	28a. Oate of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred									
ion		Certification:	1 Natural 5 Pending 2 Accident investigation	M 1 □ Yes 2 □ No									
Division of Vital Records,		rtific	3 Suicide 6 Could not be 4 Homicide determined	288. Place of injury - At home, faith, street, factory, office						ation (Street and Number or Rural Route Number, or Town, State)			
												er as stated.	
	To the Hospital	Medicai	(Check only one)  2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.								te and place, and	due to the cause(s)	
	To the h within 24 To the F complete	Σ								29	29d. Date signed (Month, Day, Year)		
,			Julien O	Weelle	200()	0	HOO	06(1	7	M	ARCH	24 2000	
KU	-3		30. Name and address of person who co	mpleted cause of de	ath (Item 2	H C3	Print)	v A	10 8	2174	20		
\(\frac{1}{2}\)	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar	r's Signatu	18	) ~ > ( ~ ~ ~	7 (0					
	Registrar MAR 28 2006 January B. Smarks												

		-	For State Registrar	State of Mar	-	artment of H			ene 2006	11361
			Hegistrar     Decedent's Name (First, Middle, Last,			inouto or i		2. Date of Death		3. Time of Death
н	Physici	an		Kenneth	Swift			Month 03	25 2006	6:10p <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	Ctr.	4b. City, Town, or	Location of Death	J	4c. County of Death	
	<b>⊏</b> Xanııı	ы	Westminster Nur			Westm	inster		Carro	011
	Funeral		5. Social Security Number 6. Sec	7. Age	(In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		place (State or Foreign untry)
	Director		214-24-8240	]M 2□F	77 Yrs.	Months Days	Mours Mill.	10-03-		ryland
	p.		Usual Residence of Decedent  10a. State 10b. County	1.	10c. City, Town or Lo	antion				10d. Inside City Limits
	shov	_	10a. State 10b. County  MD Carro		**	stead				1 ☐ Yes 2 🛣 No
	Sa-f	Director		11	mamp	10f. Zip Code		1/	og. Citizen of What Co	untar?
	ter death with the Marylan Items 23a or 28a-f show Items Item cilifical	늅	10e. Street and Number 1601 Fairmoun	t Poad			074		USA	artity :
	s 23	Funeral	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13			pecify Yes or No-	14. Race - Amer	ncan Indian,
	ter d	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2127 No	, , , , ,	Was Decedent of Hi f Yes, specify Cuba	n, Mexican, Puert	Rican, etc.)	Black, White	e, etc.
336	urs at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: W	nite
21215-0036	in 72 hours after death with the Maryland n "natural", or Items 23a or 28a-f show fedical Exartinat Ite notified at	ted	15. Decedent's Edu		16a. Dece	dent's Usual Occupa	ation	king	16b. Kind of Business/	ndustry
215	c • 34	ple	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT use retirea	)	ong		
7	D 0 = -	Completed	8		Ca	rpenter			Construc	ction
nd	d la b	Be	17. Father's Name (First, Middle, Last)	. =		1	_	ne (First, Middle, N		-
<u>ya</u>	should be nd Menta marked umatic ev	ပ္	John Jacob		401 14 77	A 11 1 (Ot	Susa		11a For	
Maryland	O1 00 mm		19a. Informant's Name/Relationship (7)  Delores V. Swi			•				
	1 and 2 Health tem 27 l	1	20a. Method of Disposition	IC - WIL	20b. Place of Dispo			, Hamps	tead, MD 20c. Location - City or	Z I U / 4 Fown, State
5	00	1	1 ☐ Burial 2 X Cremation 3 ☐ F		Carroll					
altimore,		1	<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>			2. Name and Addres			Hampstead neral Hom	
Ba	permit. Departn Imports any inju		Hallen X		The state of the s			Hamps	stead, MD	21074
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused to ne cause on each line	he death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	and	amuens	My				Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence of	00	0	0		
	Examiner		Sequentially list conditions, if any, leading to immediate	b. arte	msele	ratio V	asens	n Ois	ense	13 yr
	be sit	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					-
	xecut and Il-tran	Examlner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):					
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dicai E	l l							
687	ficate I physics the k	adic	•	d						
XO	eath certific attending p I for use as I	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		7=			23d. Date of deli	very
Ď.	death e atte d for	icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at ti		∃Ectopic pregnancy ∃ Other (s <i>pecify)</i>			Month	Day Year
P.O.	by the destached	Physiclan/Me	9 Unknown	9□ Unknown						and the second second
	es tha igned l be det	by	Part II. Other significant conditions co	ntributing to death but	not resulting in the u	nderlying cause giv	en in Part I.		pacco use contribute to es 2 □ No 3 □ Pre	the cause of death?
ecords,	w requir been si should							1 1 48	s 21 No 3 F	Spably 4 Conkilowii
ecc	e faw r has be je 2 sh	Completed						24a. Was autops	y prior to d	topsy findings available completion of cause of
H H	(0	Co						perform 1 Yes 2	1 ☐ Yes	2 No
Vital	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Oth	or	ith (Check only on		
of	shys this al di	2	1 ☐ Yes 2 ☒ No  27. Manner of Death	1 ☐ Inpatien 28a. Date of Injury		NT 3LL DOA	4 Nursing F		ence 6 Other (Spec ow injury occurred	city)
	ding After fune	tlon	1 Natural 5 ☐ Pending	(Month, Day	Year) Injury	Wor	k? Yes 2 ∐No			
Division	or Attendi after death. Director: A in by the fu	flca	3 Suicide 6 Could not be	286. Place of injur	y - At home, farm, st	reet, factory, office			reet and Number or Ru	ıral Route Number,
Div	after Direct	Certification:	4  Homicide determined	building, etc.	(Specify)			City or Town	n, State)	
	Hospita 14 hours Funeral tely filled		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	vsician: To the best of	my knowledge, deat	h occurred at the tir	ne, date and place	, and due to the ca	ause(s) and manner as ate and place, and due	stated.
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Attencompletely filled in by the fune	Medical	one)	and manner state		29c. Licens			9d. Date signed (Monti	
	To To	~	29b. Signature and title of certifier	O Pox		250. Licens			1 /	
, .	a)		Julm M	www.	ath (Item 23a) (Type	D ·	~777		JH I W	
~	10		30. Name of address of person who d	ddleton	Cro Pos	le RI	Win	timinst	3/27/200	<b>よ</b> ハ57
	190	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature		1 1 1 1		1	
	Regist	rar	MAR 2 9 21	006 Desin	w the A	early				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 7:43 P. Singleton Stauffer March 24, 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Buckingham's Choice Frederick Adamstown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Yrs. Director 212**-**38-8905 Oct.20,1913 92 <u>Pennsylvania</u> Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits s 23a or 28a-f show Maryland Frederick Adamstown 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3200 Baker Circle 21710 USA Funeral r then "naturel", or items the Medical Examiner of 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: White Š Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home . Pages 1 and 2 should be filed v tment of Heelth and Mental Hygie tant: if item 27 is marked other t jury or other traumatic event, III  $5\pm$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Scott **Nellie** Singleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Stauffer/ Son 7210 James Harris Dr. Frederick, MD 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Eurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 3/31/2006 Mt. Olivet Cemetery Frederick, MD 21. Signature of Funeral Service 22. Name and Address of Facility Stauffer Funeral Home, PA 1621 Opossumtown Pike, Frederick, Md 21702 (Anti) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or rear failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** nes monia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the et d be deteched fo o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Histhma 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an After this certificete has funeral director, page 2 autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 💆 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Medical Certification; To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 🗌 Suicide 6 Could not be determined To the Hospitel or Atte within 24 hours after de To the Funerel Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3-27-06 MD0058726 - mo 30. Name and address of erson who completed cause of death (Item 23a) (Type, Print) 3000 - D Ventrie Ct , Myersville 21773 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of	Marylan	id / Depa	artment o	of Hea	alth and N eath	Mental H	ygiene Reg. No.	106	1 363
acX.	g Vija I		Decedent's Name (First, Middle	e, Last)			.,,,,			2. Date of D	eath		3. Time of Death
	Physici		Charles D. Sn	mith						Month	Day 21	2006	0615 <sup>M</sup>
	/Medio		4a. Facility Name (If not institution		oer)		4b. City, To	wn, or Lo	cation of Death	1	4c. C	ounty of Death	
		green de la	Atlantic Genera	al Hospital			Berl:					orceste	
	Funeral	2.00	5. Social Security Number	6. Sex 7.		last birthday) Yrs.	If Under 1 \ Months D		Hours Min.		Day, Year)		place (State or Foreign ntry)
	Director		219–42–9096 Usual Residence of Decedent		62	115.				June 2	26, 19	13	MD
	land		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10d. fnside City Limits
	Mary f sh	tor	MD Word	ester	В	erlin							1 ☑ Yes 2 ☐ No
	r 28a	Director	10e. Street and Number				10f. Zip Co	ode			10g. Citize	n of What Cou	ntry?
	death with the Maryland me 23a or 28a-f show r runt be notified at	a D	107 Showell St.		(		218	311				USA	
	deal	Funeral	11. Marital Status	12. Was Deced Armed Forc	ent Ever in U	.S. 13.	Was Deceden	t of Hispa Cuban, I	anic Origin? (S Mexican, Puerl	pecify Yes or No Rican, etc.)	10- 14	. Race - Ameri Black, White	
. 9	or It	Y.	1 Never Married 2 Mar	ned 1 ☐ Yes 2 If Yes, Give	. □ <b>X</b> No	į	1 ☐ Yes 2 ☐		Specify:		s	pecify: Bl	
õ ë	ural',	d by	3 Widowed 4 Divorced		es: 								
3/21/0¢ d 21215-003	filed within 72 hours after Hygiene. ither then "netural", or Ite ent, the Matsical Examina	Completed	(Specify only highe	nt's Education st grade completed)		(Give	dent's Usual C kind of work o DO NOT use i	done duri	ing most of wor	king	TOD, KING	of Business/Ir	idustry
5 21.	withi 1606 then	mo	Elementary/Secondary (0-12)	College (1-4	lor 5+)				ailer		,	Auto Sa	los
w B	Hyg other	BeC	17. Father's Name (First, Middle,	Last)			Auco		3. Mother's Nan	ne (First, Midd			ICS
l la	Mental Mental Med	To B	unknown						Jennie	Smith			
50 - 3/21/06 0615 Maryland 21215-0036	shou and N		19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailir	ng Address (S	treet and	Number or Ru	ral Route Num	ber, City or	Town, State, Zi	p Code)
V	s 1 and 2 if Health a Item 27 la other trei		Margaret Baker/	'sister		107	Showell	l St.	., Berl	in, MD	21811		
$\frac{1.3}{6}$	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "netural", or Iteme 23a or 28a-f show any Injury or other treumatic event, the Markical Examinat runst be notified at once.		20a. Method of Disposition  1 Strain 2 Cremation	2 □ Pemoval from St	20b. F	Place of Dispo cemetery, crei	sition (Name matory or othe	of ir place)		Date	20c. Loca	tion - City or T	own, State
Ĕ	Pages ment of I ent: If Its ury or o		4 Donation 5 Other (5			Paul'	s Cemet	ery	3/27	/2006	Berl	in, MD	
3 Salt	permit. Departi Importi any Inji		21. Signature of Funeral Service	Licensee			2. Name and A		of Facility LSON Fu	noral H	iomo	8	
7 -	207 2 2		Jalana &	Clarson		1	618 Wes	st_Ro	d., Sal	isbury,	MD 21	801	
3			23a. Part1. Enter the disease, o shock, or heart failure. List	r complications that cau t only one cause on eac	used the deat ch line.	th. Do not ent	er the mode o	of dying, s	such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
20	Physician		Immediate Cause (Final disease or condition	_a Seps	Sis								Onset and Death
9	/Medical Examiner		resulting in death)	Due to (o	r as a consec	quence of):							
1	LAGITITIE	_	Sequentially list conditions,	b	CAN E THE ST								
	ed sit	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (c)	as a conseq	luence oi).							
0,	and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or	ras a consec	uence of):							
,09 8760,	icate be executed physicien and s the burial-transit	a E				,							
687	icate phys s the	dical		d									
×	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burral-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco							23	d. Date of deliv	rery
B	leath atter	clar	in the past 12 months?		th 2∏Feta ntattime of o		Ectopic pregi Other (speci					Month	Day Year
O.	it the d by the tached	hysi	9 Unknown	9□ Unknov	vn	100			Total State				
7. P.C.	ires that signed b	by P	Part II. Other significant conditi	ons contributing to dea	th but not res	sulting in the u	nderlying cau:	se given	in Part I.	23e. Dio	tobacco us	e contribute to	the cause of death?
ords	v require been sig should b	Pa Pa								1 [	Yes 2	No 3 ☐ Pro	bably 4 ☐ Onknown
	aw re as bee 2 sho	Completed								24a. Wt		24b. Were aut	opsy findings available ompletion of cause of
S. Z. Z. Z. Z. Z. Z. Z. Z. Z. Z. Z. Z. Z.	The isate hapage	E								per 1 Tyes	lopsy formed?	death?	2 De la cause of
		Bec	25. Was case referred to medica	ıl .	/		71177	2	6. Place of Dea				
7 =	Physicien: this certific al director,	10	examiner? 1 Yes 2 140	Hospital: 1	patient 2	ER/Outpatier	nt 3 DOA	Other:	4 🗆 Nursing H	lome 5□Re	sidence 6	Other (Spec	ify)
2000	_ = =	Ë	27. Manny of Death 1 Natural 5 ☐ Pendi	28a. Date of (Month)	Injury Day Year)	28b. Time o Injury	f 28c	. Injury at Work?	t	28d. Describ	e how injury	occurred	
ු Givision	ttendir death. ctor: Al y the fu	Certification:	2 ☐ Accident Invest	igation			М	1 🗌 Ye:	s 2 □ No				
≅	or Att after d Direct Jin by t	Ē	3 Suicide 6 Could 4 Homicide deter	nined 286. Place C	of Injury - At h g, etc. <i>(Speci</i>	iome, farm, sti <i>fy)</i>	reet, factory, c	office			(Street and own, State)	Number or Rui	ral Route Number,
	urs a aral D		00.0.00		The left man have	chart Medical Calcula	e construction	martin Harrison (1917)	Description of the Control	- TAN YOR - 417 - 1 A A A A A		Life i economic de trace	vanities.
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier 1 ortifyi (Check only 2 Medical	ng Physicians To the bas Examiner: On the bas and manne	sis of examina	ation and/or in	n occurred at vestigation, in	tha time, my opin	ion, death occu	rred at the time	e, date and p	lace, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certific				29c. L	icense n	umber		29d. Date	signed (Month	. Day, Year)
	F 3 F 8		) c////	/ 110				5361			21	1/06	
	Br		30. Name and address of person	who completed cause	of death (Ite	m 23a) (Type	Print!	100		_			
	0/2		Andrea K	Baler n	up 9	733	Heal	tan	sug D	Berl	in K	m 21	811
	Sta	ite	31. Date filed (Month, Day, Year	) 62. Re	gistrar's Sign	ature	10 = 1	14141		(.		·	
4	Regist		MAR 2	4 2006	all an -	M M	Land .		-				

ORIGINAL

			1 - For State Registrar	State of I	Marylan			nt of H <i>te of L</i>				jiene leg. No.	06	11364
	Physici	an	1. Decedent's Name (First, Middle, L	a st)							2. Date of Dea	Day	Year	3. Time of Death
	/Medic	al	Edgar	L.		Smit				-10	March	-	.006	8:30 р м
	Examin	er	4a. Facility Name (If not institution, g Crofton Conval		•			, Town, or		or Death			nty of Death ne Ar	undel
	Funeral			Sex 7.		last birthday)	If Und	er 1 Year	If Under		8. Date of Birtl	1	9. Birth	polace (State or Foreign
	Director		217-16-3391	XXM 2□F	85	Yrs.	Month	Days	Hours	Min.	Dec 24	, Year) 1920	Mar	yland
	D &		Usual Residence of Decedent  10a. State 10b. County		10c Cit	ty, Town or Lo	cation							10d. Inside City Limits
	rehor	o	MD Anne Ar	umdo1		everna		•						1 Yes 2 No
	28a-	rect	10e. Street and Number	under	30	everna		ip Code				l0g. Citizen o	f What Cou	
	3a oi	Funeral Director	780 Abigail Wynd	Court				211	46			USA		
	dear dear	ner	11. Marital Status	12. Was Decede Armed Force	nt Ever in U	.S. 13.	Was Dec	edent of Hi	ispanic Or	igin? (Spec	cify Yes or No- Rican, etc.)		ace - Amer lack, White	ican Indian,
2	s arre	by Fu	1 Never Married 2 Married	1 XYes 2 [ If Yes, Give	□No WW			2 X No	Specify:			Spec		ite
5.	tural al Ex		3 XWidowed 4 ☐ Divorced	Year or Date	s:	16a. Dece	dent's He	ual Occupa	ation			16b. Kind of		
2	n na	Completed	(Specify only highest g	rade completed)		(Give	kind of v		during mos	it of workin	g	TOD. KING OF	Du3111033/11	ildustry
7	giene giene	Com	Elementary/Secondary (0-12)	College (1-4c	or 5+)	Bricl	klay	er				Cons	truct	ion
3	al Hy d oth	Be	17. Father's Name (First, Middle, Las	st)							(First, Middle,	Maiden Sumi	ame)	
2	Meni	T <sub>0</sub>	Edgar L. Smith,		- 4						eitch			
Ma	n 2 sn thand 7 le m traum		19a. Informant's Name/Relationship Kevin Smith (Sor	-			-				Route Numbe Sever			
נ ע	Heali Heali tem 2		20a. Method of Disposition	1)	20b. F	Place of Dispo	sition (N	ame of			ate Devel	20c. Location		
2	ages ent of ht: If I		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		te	semetery, crer Ly Cros			1	3-23-	-3006	Brook1	vn. M	ID
	permit. Pages 1 and 2 should be lided within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Department of Health and Mential Hygiene. See The Marked other then "natural", or iteme 23a or 28a-f ehow eny Injury or other traumatic event, the Medical Examiner must be notified at Once.		21. Signature of Funeral Service Lie		110.								711, 12	
ă	22. Name and Add Hardest 12 Ridg								ly Av	enue	,_Annap	olis,	MD 21	401
	Physician /Medical Examiner		23a. Partī. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Cere f	ine.	ulax		CCCA	5. 1	,	respiratory ari	est,		Approximate Interval Between Onset and Death
1	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseq	uence of):								
5	be exectivities and purial-tre	al Exa	that initiated events resulting in death) Last	C. Due to (or	as a conseq	uence of):								
	meate g phys	edical		d										
.OO.	To the propriet or Attending Frigstcent: The law requires that the beam certificate be executed.  To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	I death 3	Ectopic Other (	pregnancy specify)					Date of delivery	very Day Year
'n	igned b	þ	Part II. Other significent conditions	contributing to death	but not res	ulting in the u	nderlying	cause give	en in Part					the cause of death?
5	neen s	eted									1 🗆 Y			
ייין דיין	ne law sate has b page 2 s	Completed								_	24a. Was a autop perfor 1 Yes	n 24b sy med? 2 No	prior to c death? 1 \( \sum \text{Yes}	topsy findings available ompletion of cause of 2 No
	cualific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Oth			(Check only o			
5	r this rai dir	7	1 Yes 2 No  27. Manner of Death	28a. Date of Ir		ER/Outpatier 28b. Time of			4 1/2 1/1		ne 5 ☐ Resid 8d. Describe h			ify)
5	th.	tion	1 Satural 5 Pending 2 Accident investigati	(Month, i	Day Year)	Injury	м	28c. Injury Work	k? Yes 2□			on injury coo	3,103	
	a or Atter s aftar dea il Director id in by the	Certification:	3 Suicide 6 Could not determine		Injury - At ho etc. <i>(Specif</i>	ome, farm, str y)	eet, facto	ory, office		2	8f. Location (S City or Tow		nber or Ru	ral Route Number,
	e nospii 24 hour e Funera letely fills	edical (	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exc	Physician: To the be miner: On the basis and manner	s of examina	wledge, death tion and/or in	h occurre vestigation	dat the timen, in my op	ne, date ar pinion, dea	nd place, a ath occurre	nd due to the o	ause(s) and r late and place	manner as e, and due	stated. to the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier					9c. License			2	9d. Date sign	ned (Month	, Day, Year)
			De Colla	MD			2	038	958			3/22	106	
			30. Name and address of person who	o completed cause of	death (Item	Craun	Print)	1/120	11.0	10 0	D. A	CVNIO	101)	21061
34	Sta Registr	_	31. Date filed (Month, Day (Year)	2. Regi	strar's Signa		J	V	7	<i>VV</i> V	Un	11116	- 1 <u>V</u>	100/

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of M	arylan	•	artmen tificate					Reg. N	UUD	1136	55
	Physici	an	Decedent's Name (First, Middle	_	a.m.	n auro					2. Date of De Month MARCH		ay Yea	3. Time of	
	/Medic	al	THOMAS  4a. Facility Name (If not institution	D.		ECHER	4h City	Town or	Location of	of Death	MARCH		c. County of D	23:45	Р м
	Examin	er	CALVERT MANOR			R	, ,	ING		or Doutin			CECIL		
	Funeral Director		5. Social Security Number 152 10 8382		ge (In yrs. I	ast birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bi (Month, Da APR 11,	ay, Year	9. 1	Birthplace (State of Country) LLAWARE	or Foreign
	and w		Usual Residence of Decedent  10a. State 10b. County	,	10c. City	/, Town or Lo	cation							10d. Inside C	ity Limits
	Maryl -f sho	호	DE SUSSE	v	DEI	новотн	REAC	н						1 ☐ Yes	2 <u>K</u> No
	with the	al Director	10e. Street and Number 17 POWDERHORN		TCL	повотп	10f. Zip						itizen of What	Country?	
036	be filed within 72 hours after death with the Maryland Hygiene. d other than "natural", or items 23s or 28s-f show event, the Medical Examinar must be notified at	by Funeral I	11. Marital Status  1 ☐ Never Married 2 ☐ Mar  3 ☒ Widowed 4 ☐ Divorced	If Yes Give	?		Was Deced f Yes, spec 1 ☐ Yes 2		spanic Ori n, Mexicar Specify:		ecify Yes or No Rican, etc.)	D-	14. Race - A Black, W Specify:	merican Indian, hite, etc. WHITE	
21215-0036	within 72 ho ene. than "natur he Medical I	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed)  College (1-4or	5+)	16a. Dece (Give life. CHEMI	kind of wor DO NOT us	k done d e retired	furing mosi )	t of worki	ing		Kind of Busine		
9	filed Hygie Sther	e Co	17. Father's Name (First, Middle,	Last)		CHEMI	CAL U	FERA		er's Name	(First, Middle			າວ	
lan	should be nd Mental marked o imatic eve	To B	FRED STECHER	}					N	1ARY	MILLER				
-	d 2 sh th and th sm 7 ts m traum		19a. Informant's Name/Relations JUDITH CAMPBE			1	•	•			ARK, DE			e, Zip Code)	
a a			20a. Method of Disposition 1 🖾 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5		, a	lace of Dispo emetery, crei SAINT	natory or of	ther plac			30,200		•	or Town, State	
Balti	permit. Page Department of Important: If any injury or ance.		ALL SAINTS CEMETERY MARCH 30,2006 WILMIN  21. Signature of Funeral Service Licensee  MEALEY TUNERAL HOMES  MO0784  PO BOX 2866, WILMINGTON DE 19805  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,												
) 1	Physician /Medical		23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	t only one cause on each	ine. te	Do not ent	er the mode		g, such as					Approximat Interval Bet Onset and I	ween
	death certificate be executed to a strending physician and to for use as the burial-transit	icai Examiner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	card	se ld uence of):	eutt Infa	ret	ailu	Me .				2-3w	ree las
	death certific e attending p ed for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 🗌 Fetal	death 3	Ectopic pro						23d. Date of Month	,	Year
0	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditi	ons contributing to death	but not resu	ulting in the u	nderlying ca	ause give	en in Part I.		23e. Did	4		e to the cause of c	
œ	The ate ha	Completed									24a. Was auto perfe 1 \square Yes		prior death		available ause of
Vital	Physician: this certifical ral director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 🔲 Inpati	iont O	ER/Outpatier	* a \( \bar{\alpha}\)	Othe			me 5☐Res		6 []Other (6		
of	e fe	<del> </del>	27. Manner of Death 1 Natural 5 ☐ Pendi	28a. Date of Inj		28b. Time o Injury		8c. Injun Work			28d. Describe			респу)	-
=	tal or Attendir s after death. al Diractor: Al ed in by the fu	Certification;	3 Suicide 6 Could 4 Homicide deterr	not be 28e. Place of Ir	njury - At ho	ome, farm, str	eet, factory	, office			28f. Location ( City or To			Rural Route Num	nber,
	Hospit	edical C	29a. Certifier (Check only one) Certifyi	ng Physician: To the besi I Examiner: On the basis and manner s	of examinal	wledge, deat tion and/or in	n occurred avestigation,	at the tim	ie, date an pinion, dea	d place, ath occurr	and due to the ed at the time,	cause(s date ar	s) and manner nd place, and o	as stated. due to the cause(s	;)
)	To the vithin to the comple	Me	29b. Signature and title of certifie	er (					number )583	351	1	29d. Da	ate signed (Mi	onth, Day, Year)	
	8		30. Name and address of person		~ 1	23a) (Type,	Print)		MD		1911		PINO		
	Sta Registr		31. Date filed (Month, Day, Year		trar's Signa		alle	71	עייי		1111				

	•	For State Registrar	State of N	naryland		artment of H rtificate of I		and Mental H	Reg. Ño.	006	11366	
		1. Decedent's Name (First, Middle, La	st)					2. Date of I	Death Day	Year	3. Time of Death	
Physicia /Medic		Dargain Lee	Stalvey	,				March			1935 M	
Examin		4a. Facility Name (If not institution, giv	e street and numbe	r)		4b. City, Town, or	Location of	of Death	4c.	County of Death		
	н	Dorchester G	eneral	HOSPI	tal	Camb			1	orches.		
Funeral		5. Social Security Number 6. S	Sex 7. A	ige (In yrs. la		If Under 1 Year Months Days	If Under Hours	Min. (Month, I	Jay, Year)		place (State or Foreign intry)	
Director		218-48-0901 Usual Residence of Decedent	W ZU I	59	Yrs.			August	t 2,	1946 Sou	th Carolina	
death with the Maryland ms 23a or 28a-f show tinuat Le troffiled at	tor	10a. State 10b. County 10c County 10c Dorche	ster	10c. City	, Town or Lo	secretary	,				10d. Inside City Limits 1 XYes 2 ☐ No	
with the	Funeral Director	10e. Street and Number 124 Academy St	reet.			10f. Zip Code	21664	1		zen of What Cou JSA	intry?	
Jeath Jus 2,	era	11. Marital Status	12. Was Deceder	nt Ever in U.S	S. 13.	Was Decedent of H		gin? (Specify Yes or f i, Puerto Rican, etc.)	No-	14. Race - Amer		
i	by Fur	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces 1 ☐ Yes 2 5 If Yes, Give Year or Dates	<b>₹</b> No		If Yes, specify Cuba 1 ☐ Yes 2121 No	Specify:	i, Puerto Rican, etc.)	- 1	Black, White Specify: Wh		
ad within 72 hours aff giene. er than "natural", or i. the Medical Exam	Completed by	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		r 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done o DO NOT use retired	ation during mos	t of working		nd of Business/li	,	
d with	E O	7				mechani	.C		re	efrigera	ıtion	
othe vent.	3e C	17. Father's Name (First, Middle, Last	)			:	18. Mothe	er's Name (First, Midd	lle, Maiden	Sumame)		
Aenta Aenta rked tic e	To Be	Louis Stalvey					Bo	nnie Lewis	5			
id 2 should be filed within the and Mentat Hygiene. 77 is marked other than traumatic event, the Ma		19a. Informant's Name/Relationship ( Vicky Stalvey	Турө, Print) wife					er or Rural Route Num ecretary, 1		r Town, State, Zi 1664	ip Code)	
1 and 1 Health tem 27		20a. Method of Disposition		20b. Pl		osition (Name of matory or other place		Date		cation - City or T	own, State	
ages ant of t: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from Stat	Ð			1	3/27/06	Cal	lisbury,	M	
permit. Pages 1 a Department of Hee Important: If item any Injury or othe	1	21. Signatur of Funeral Service Lice		Sai	4	y Cremato 2. Name and Addres	_	The state of the s		-		
permi Depar Impo any Ir		21. Signatur in Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Hom 700 Locust St., Cambridge, MD 2161										
		23a. Party Enter the disease, or com	plications that caus	ed the death						21013	Approximate Interval Between	
Priysician /Medical Examiner		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a Or Due to (or b	ganic	Bience of):	rain S Heohol	and, Ab	use			Onset and Death	
ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or a	as a consequ	ence of):							
that the death certificated by the attending phydetached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown	2 Fetal at time of de	death 3	□Ectopic pregnancy □ Other (specify) _			-	23d. Date of deli Month	very Day Year	
w requires that the been signed by th should be detache	by	Part II. Other significant conditions	contributing to death	but not resu	llting in the t	inderlying cause giv		1.0			the cause of death?	
e taw has b	Completed	Strok					·	24a. Wi au pe 1 □ Yes	topsy rformed?	24b. Were aut prior to c death? 1 \( \subseteq \text{Yes}	topsy findings available ompletion of cause of 2 No	
ician: Ti	ø	25. Was case referred to medical	5				26. Place	of Death (Check onl		, (100	40110	
	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	itient 2	R/Outpatie	nt 3 DOA Oth	er: 4 □ Nu	ursing Home 5 🗆 Re	sidence (	6 □Other (Spec	ify)	
ffer ffer		27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Ir (Month, I	njury Da <i>y Y</i> ea <i>r)</i>	28b. Time of Injury	of 28c. Injur Wor		28d. Describ				
To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral or	Certification;	3 Suicide 6 Could not be determined	28e. Place of	Injury - At ho etc. (Specify	me, farm, st	reet, factory, office			(Street an Town, State		rai Route Number,	
Hospita 24 hours Funeral	edica C	29a. Certifier 1 Certifying P (Check only one)	hysician: To the be miner: On the basis and manner	of examinat	wledge, dea ion and/or ir	th occurred at the tin estigation, in my o	ne, date ar pinion, dea	nd place, and due to the time	ne cause(s) ne, date and	and manner as I place, and due	stated. to the cause(s)	
o the ithin o the	Med	29b Signature and title of certifier				29c. Licens	e number		29d. Dat	e signed (Month	, Day, Year)	
F ≥ F 8						DE	7060	7060	Ma	rch 25	7001	
			completed cause of	f don't /**	23a) /T			~ ~ ~	100	wr(L)	,0006	
		30. Name and address of person who David C. White,					Comb	oridge, MD	2161	1.3		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month TAYLOR **GWENDOLYN** 2006 MARCH 26 8:00 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S 14903 RUNNING FORCE ROAD BOWIE 5. Social Security Number 6 Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🕅 F Yrs. 245-06-8917 48 29 1957 NORTH CAROLINA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No BOWIE MD PRINCE GEORGE'S 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20715 14903 RUNNING FORCE ROAD 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECURITY GUARD PRIVATE l yr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **EMMA** BARNES LUTHER TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHEILA TAYLOR/DAUGHTER 14903 RUNNING FORCE ROAD BOWIE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ Removal from State GARDEN OF GETHSAMANE 4 ☐ Donation 5 ☐ Other (Specify) 4/2/2006 ROCKY MOUNTIAN, NC 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter thy disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition LUNG CANCER resulting in death) Due to (or as a consequence of):
BRAIN METASTASIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) arwal 3-27-06 MD 31506 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANITA AGGARAL M.D. 110 IRVING STREET N.W. WASHINGTON, DC

State

31. Date filed (Month, Day, Year) MAR 2 8 2006 . Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

**Physician** 

/Medical

Examiner

**Funeral Director** 

Completed by

Be

ပ္

by Physician/Medical Examiner

Completed

Be

Medical Certification: To

**Funeral** 

Director

item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Micdical Examinar must be notified at

al Hygiene.

ō

be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 permit. Pages Department of Important: If it any injury or o

**Physician** 

Examiner

for use as the burial-tran

page 2 should be detached

director.

the

completely filled in by

certificate has been

this funeral

Diractor: After or Attending

To the Hospitel or within 24 hours at To the Funeral D

ettending physicien

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

/Medical

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Libby Ruth Thompson 2006 2:29 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 ☐ M 2 🗓 F Director 579-46-7565 71 May 3, 1934 North Carolina Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f ehow the Medical Exeminer must be notified at 1 XYes 2 No Director Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20020 2327 Chester St., S.E. United States Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: Black 3 Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Coding Clerk Government permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie Importent: If item 27 is marked other to any Injury or other traumatic event, Impone. other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Richard McLaughlin Meta Hack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rudolph Hack/Brother 686 - 4th St., N.E. Wash., DC 20002 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 3/28/2006 Clinton, MD 21. Signature of Fineral Service Licenses 22. Name and Address of Facility Stewart Funeral Home Reval 4001 Benning Rd., N.E. Wash., DC 20019 23a. Part1. Ef er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Carre (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conseque Examine Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical signed by the attending physical be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant condition or tributing to death out not resulting the up 23e. Did tobacco use contribute to the cause of death? erlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Yes 2X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 12 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 3 Suicide 6 ☐ Could not be within 24 hours after de To the Funerel Directo completely filled in by the Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 Carroll Ave., Takoma Park, MD 20912 KANGO NASREEN 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 2 8 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** March DOROTHY VIRGINIA TUCKER 22 L: 15a.™ 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Memorial Hospital Lumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
APRIL 20, 1911 5. Social Security Number 7. Age (In vrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 94 Yrs. Director 220-10-0298 MARYLAND Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. Intent of Heelth and marked other then "naturel", or Items 23s or 28s-f show 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 27 le marked other then "naturel", or items 23a or 28a-f show treumatic event, the Medical Experimer must be natified at 1 ☐ Yes 2 ☐ No Director MD LAVALE ALLEGANY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 936 NATIONAL 21502 HIGHWAY U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) UNKNOWN CLERK BUSINESS OFFICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SISLER ROSE BELLE GERLACH WILLIAM 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WILLIAM TUCKER / SON 936 NATIONAL HIGHWAY, LAVALE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 5 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of tmportant: If eny injury or once. 03/25/2006 4 ☐ Donation 5 ☐ Other (Specify) GREENMOUNT CEMETERY CUMBERLAND, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** week pnemmana /Medical Due to (of as a consequence of) **Examiner** 1 week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events physician and resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ★ Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? certificate 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ို 1 ☐ Yes 🔑 ☐ No 1) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ours after death.

nerel Director: After this filled in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 19∰Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospitel within 24 hours a To the Funerel I 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03/22/06 8 D60478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar About M.D

31. Date filed (Month, Day, Year)

MAR 2 7 2006

Baltimore, Maryland 21215-0036

Box 68760.

Division of Vital Records, P.O.

25 Kent 32. Registrar's Signature Cumberland, Maryland 21502

			Please  1 - State Registrar		<b>it in Black Ir</b> aryland / Dep <i>Ce</i>		lealth and N	Mental Hygi	_	11370
	Physic		Decedent's Name (First, Middle, Last     Mary V. Torchia					2. Date of Death Month		3. Time of Death
	/Med Exami		4a. Facility Name (If not institution, give		· · ·	4b. City, Town, o	Location of Death		4c. County of Death	
			Baltimore Wash			Glen	Burni		Anne P	
~	Funeral Director		5. Social Security Number 6. S 220-24-0849  Usual Residence of Decedent	ex 7. Ag □ M 2 131 F	e (In yrs. last birthday 89 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Aug. 18	9. Birth Cou	place (State or Foreign intry) TN
MARY	laryland 21215-0036 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "naturel", or Items 23a or 28e-f show eumetic event, the Modical Everalizer must be notified.	ctor	10a. State 10b. County	Arundel	10c. City, Town or L	ocation Severn	a Park			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	vith th	Funeral Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	intry?
<b>E</b>	eath v	erai	249 Cypress Cree	12. Was Decedent	Ever in U.S. 13		1146	pecify Yes or No-	USA 14. Race - Ameri	ican Indian
rchin,	U36  ours after d  rel; or Iten	b	1 Never Married 2 Married 3 XWidowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	Specify:	Rican, etc.)	Black, White	
10	5-0 72 hc	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Give	edent's Usual Occup	during most of work	ting 1	6b. Kind of Business/II	ndustry
1— ;	within sare.	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+) life.	DO NOT use retired	lyst		Federal Governmen	t
	re, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hygiene. item 27 is marked other then "naturel", or Items 23a or 28e-f show other treumetic event, the Modical Eventher must be notified at	To Be Co	17. Father's Name (First, Middle, Last) Riley Anderson				18. Mother's Nam	e (First, Middle, M Chitwood		
	Tary 2 shou and M is mar		19a. Informant's Name/Relationship (7	Гуре, Print)	19b. Mail	ing Address (Street	and Number or Rur	al Route Number,	City or Town, State, Zi	p Code)
	and 2		Morris E. Lay/Co	ousin	14	North Mai	n Street,			1783
	Baltimore, ME permit. Pages 1 and 2 Department of Health as Importent: If item 27 is any injury or other tree		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐			osition (Name of or other place)		27.	Oc. Location - City or T	
	litin artmer artmer ortent injury		<ul> <li>4 □ Donation 5 □ Other (Specify</li> <li>21. Signature of Funeral Service Licent</li> </ul>	<u> </u>		en Memori 2 Name and Addre			Glen Burnie	
1			Les ()	m		Barranco 495 Gov.	& Sons, F Ritchie H	7.A. Seve Iwv. Seve	rna Park Fi rna Park, I	uneral Home MD 21146
	st,	Approximate Interval Between Onset and Death								
	icate be executed managed by physician and physician and street street burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Ent. it industrial, Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence of):  a consequence of):  a consequence of):					
	DIVISION OF VITAL RECORDS, P.O. BOX 68 of the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the I	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death 3	⊒Ectopic pregnancy ⊒ Other (specify)			23d. Date of deliv Month	rery Day Year
	COLCS, P	by	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the t	anderlying cause give	en in Part I.	23e. Did toba	acco use contribute to l	the cause of death?
	LIVISION OF VITAL HECOFGS, I or Attending Physicien: The law requires It after death. Director: After this certificate has been signed in by the funeral director, page 2 should be or	Completed						24a. Was an autopsy perform	prior to co	opsy findings available ompletion of cause of
	VITAL P	Be	25. Was case referred to medical examiner?	Unanital: - •				h (Check only one	)	
3	Physi this c	2	1 ☐ Yes 2 No	Hospital: 1 Inpatie	The second secon	nt 3 DOA	or: 4 ☐ Nursing Ho	ome 5 Resider	nce 6 Other (Speci	fy)
:	on on or other th.  After a funer	tion	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injui (Month, Day	Year) Injury	Worl	(? Yes 2 □ No	Edd. Describe flow	wantary occurred	
	DIVISION of the north of the the the the the the the the the the	Certification:	3 Suicide 6 Could not be determined		ury - At home, farm, st c. (Specify)	reet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,
	LIVIS To the Hospitel or Attention 24 hours after de within 24 hours after de To the Funerel Directo completely filled in by the	edical	(Check only 2   Medical Exam	ysicien: To the best on the basis of and manner sta	examination and/or in	ivestigation, in my or	pinion, death occur	red at the time, dat	use(s) and manner as stee and place, and due t	to the cause(s)
	To To Con	×	29b. Signature and title of certifier  Herry Trus	rais My		29c. License	7 415		d. Date signed (Month,	
	19		30. Name and address of person who of Ballimore Wash.	~ HON MY	Lical Co	iter, He	mry F	Francis	mo	
	St Regist	ate rar	31. Date filed (Month, Day, Year)  MAR 2.4 200	16 Alexander	ar's Signature	***				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland		irtment of Hotelin of Land		-	giene Reg. No.	06	37
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Cecilia	Elizabeth	Т	hompson		2. Date of De Month March 2		6 Year	3. Time of Death 3:10 p. M
	Examir		4a. Facility Name (If not institution, give s 1206 Ramb1ewood D			4b. City, Town, or Annapoli		h		inty of Death	
	Funeral Director	f	5. Social Security Number 6. Sex 215-14-4545	7. Age ( <i>In yrs. las</i>	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Nov. 2,	th y, Year) 1921	Cou	place (State or Foreign intry) 7 land
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or itama 23e or 28e-f show aumatic event, if a Medical Exartérar must be routined at	Director	Usual Residence of Decedent	del Anna	Town or Lo	cation			10g. Citizen		10d. Inside City Limits 1 ☐ Yes 2☐ No XX
	ath with a 23a or neat be	rai Di	1206 Ramblewood D			21401			United		
980	ours after de rai', or Itame Exemination	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	l1	Vas Decedent of His i Yes, specify Cubar I ☐ Yes 2X No	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No to Rican, etc.)	1	Race - Ameri Black, White ec <i>ify:</i> Wh	
21215-0036	within 72 ho lene. than "natur	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	ation completed) Colfege (1-4or 5+)	(Give . life. [	lent's Usual Occupa kind of work done d DO NOT use retired) maker	tion uring most of woi	rking		f Business/Ir	ndustry
and 2	I be filed ntal Hygi ed other	Be	17. Father's Name (First, Middle, Last) Herman Bertling		1101110			me (First, Middle,			
Maryland	should and Me s mark umatio	으	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Street a	Mary Ga nd Number or Ru		er, City or To	wn, State, Zi	p Code)
2	1 and 2 Health a om 27 i		Mary Louise Polk 20a. Method of Disposition	20h Plac	e of Disno	Ramblewoo		nnapolis		21401 on - City or T	own State
altimore,	Pages nent of ant: if it ury or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	etery, cren	natory or other place an Cremat	ory Man 20(	ch 25,			Virginia
Balt	permit. Pages 1 and 2 should be Depertment of Health and Menta Important: if Item 27 is marked any Injury or other traumatic e once.		21. Signature of Fineral Service License		vent Fun 2 110 An			ition Ser. 21401			
4	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	a cause on each line.		er the mode of dying					Approximate Interval Between Onset and Death
10°	/Medical Examiner	10	resulting in death)	Due to (or as a consequer	nce of):						1
	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent							
58760,	icate be executed physician and s the burial-transit	dical E	d								
O. Box 6	the death certific y the attending p ched for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 1 Yes 2 No 9 Unknown	Sc. If yes, outcome of pregnance  1 Live birth 2 Fetal de  4 Pregnant at time of deat  9 Unknown	eath 3	Ectopic pregnancy Other (specify)			23d.	Date of deliv Month	rery Day Year
ords, P.	The law requires that the de ate has been signed by the a page 2 should be detached	by	Part II. Other significant conditions conditions			iderlying cause give		23e. Did t			the cause of death?
al Records,	The lar ate has page 2	Completed						24a. Was autop perfo 1 \( \text{Yes}		b. Were autoprior to codeath?	opsy findings available ompletion of cause of
Vital	hysicial his certif	To Be	25. Was case referred to medical examiner?  1 \sum Yes 2 No	ospital: 1   Inpatient 2   EF	VOutpatien	3 DOA Othe		ath (Check only colone 5 Residence 5		Other (Speci	fy)
ouo	nding Ph tth. :: After thi e funeral		27. Manner of Teath  1 Natural 5 Pending Accident Investigation	28a. Date of Injury 28 (Month, Day Year)	Bb. Time of Infury	28c. Injury Work M 1 \( \sum Y	at ? ′es 2 □ No	28d. Describe I	now infury oc	curred	
Division of	To the Hospital or Attanding Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Pface of Injury - At home building, etc. (Specify)	e, farm, stre	eet, factory, office		28f. Location (: City or Tox		ımber or Rur	al Route Number,
	Hospi 24 hour Funer etely fill	Medicai	29a. Certifier (Check only one)	er: On the best of my knowle er: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the tim restigation, in my op	e, date and place inion, death occu	e, and due to the arred at the time,	cause(s) and date and plac	manner as s ce, and due t	stated. to the cause(s)
	To the To the Comple	Me	29b. Signature and title of certifier	uffe		29c. License	number	-	29d. Date sig		
•			30 Name and address of person who cor	npleted cause of death (Item 2)	3a) (Tvoe. I	Print)	D7/9	2004	ک	-24	-06 ille ND, 21108
	1.8/ <b>5</b> (8) 1 1 1 1			MD 8601	Vex	erans i	Highu	vary,	rue	lessi	illeNB
	Sta Registr	V5241	31. Date filed (Month, Day, Year)  MAR 2 7 2	006 Applicate A	A A	Sand		0			21108

			FUI	artment of Health and Menta rtificate of Death	Al Hygiene Reg. No: 006   1372
	Physici	an	Decedent's Name (First, Middle, Last)	j 2. Dati	te of Death 3. Time of Death
4	/Medic		Deatrice Iwnbo	(UGV) 0	4-03-20de 12:20AM
	Examin	er	4a. Facility Name (If not institution, give street and number)  Long View Nursing Home	4b. City, Town, or Location of Death Manchester	4c. County of Death Carroll
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year If Under 24 Hrs. 8. Date /Mo	e of Birth (State or Foreign Country) t. 18, 1925 Maryland
	Director		205-16-6119 1 M 2MF 80 Yrs.  Usual Residence of Decedent	Sep	t. 18, 1925 Maryland
	yland		10a. State 10b. County 10c. City, Town or Lo	ocation	10d. Inside City Limits
	e Mar	ctor	MD Carroll Manche	ster	1 ☐ Yes 21⁄2 No
	with th	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	eath v	eral	3332 Main Street  11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Specify Ve	U.S.A.
36	be filed within 72 hours after death with the Maryland the lygiene.  Id hygiene.  Id other then "natural", or items 23a or 28a-f show other then "natural", or items 23a or 28a-f show event. The Madical Examinar must be mailised at	by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican, 6  1 Yes 2 No Specify:	Black, White, etc.  Specify: White
21215-0036	2 hour		15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. Kind of Business/Industry
215	thin 7	Completed	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working DO NOT use retired)	
N	filed wi Hygien ther th			spector	Manufacturing  Middle, Maiden Sumame)
Maryland	uld be fi Mental H irked ot itic ever	To Be	17. Father's Name (First, Middle, Last) Armond B. Jones		na McComas
ary	2 should and Men Is marke aumatic	۲	19a. Informant's Name/Relationship (Type, Print) 19b. Maili	ng Address (Street and Number or Rural Route	Number, City or Town, State, Zip Code)
	s 1 and 2 should f Health and Men item 27 Is marke other traumatic			1 S. Hunter Rd., H	
Baltimore,	Pages 1 nent of Hi int: If iter iry or oth		LADUIR 2 DOMINICON SENTINOVALION SIRIO 1 NAT. + D-	matory or other place)   April 6	20c. Location - City or Town, State
Ħ			'4 Donation 5 Other (Specify) Cemet	ery 2006	New Freedom, PA Hartenstein Mortuary, Inc.
Ba	permit. Departr Importa any inji		+ xarienstein	Freedom, PA 17349	
			23a. Part. Enter/the disease, or complications that caused the death. Do not en shock, or peart failure. List only one cause on each line.	ter the mode of dying, such as cardiac or respir	ratory arrest, Approximate Interval Between Onset and Death
13	Inysician	4	Immediate Cause (Final diseas) or condition a. a.	onarysyndion	e/MI minutes
	/Medical Examiner		Due to (or as a consequence of):	artisus di sin	0
		jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	wing access	- year
K	acuted ind transit	Examiner	triat initiated events		
8760,	cate be executed bhysician and the burial-transit	al Ex	resulting in death) Last — Due to (or as a consequence of):		
687	ficate p physis is the	edical	d.	.041	
Вох	h certi ending	M/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetel death 3 [	⊒Ectopic pregnancy	23d. Date of delivery
P.O. B	The law requires that the death certific ste has been signed by the attending p page 2 should be detached for use as	by Physician/Me		Other (specify)	Month Day Year
ر. ح.	s that i	y Ph	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I. 23	e. Did tobacco use contribute to the cause of death?
ords	w require been sig should b		chonic renal failure		1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
ecc	e faw re has be ge 2 sh	Completed	- Farkinson disease	248	a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of
ᆵ	: The cate h		dementio	1	performed? death? ] Yes 2 No 1 ☐ Yes 2 ☐ No
₹	Physicien: r this certific ral director,	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	26. Place of Death (Check	
o [	g Phy er this eral d	n: To	27. Manner of D ath 28a. Date of Injury 28b. Time of		Residence 6 Other (Specify)
ion	andin path. pr: Aft	atio	2 Accident investigation	M 1 Yes 2 No	
Division of Vital Records,	or Atter after de Directe in by t	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	eet, factory, office 28f. Loc C/ty	cation (Street and Number or Rural Route Number, y or Town, State)
_	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier (Check only  Certifying Physician: To the best of my knowledge, deat  Medical Examiner: On the basis of examination and/or in	h occurred at the time, date and place, and due	s to the cause(s) and manner as stated.
	the I	Medical	one) and manner stated.  29b, Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	7 × 0				4/3/06
•	1.1		30. Name and address of person who completed cause of death (Item, 23a) (Type,	Print) #1006/206 Manchester Mi	1/5/5/5
	10		4175 A Janover Rike,	Marchester M.	D 21102
	Sta Registr	-	APR 1 0 2006	le	

	·	For State Registrar	State of Maryland / De	epartment of F Dertificate of			iene <sub>eg. No.</sub>	11373					
Dhuaisia		1. Decedent's Name (First, Middle, La	st)			2. Date of Deat Month		3. Time of Death					
Physicia /Medic		Ralph W. T	alley			March	19 2006	12:00 P M					
Examine		4a. Facility Name (If not institution, giv			r Location of Deal	th	4c. County of Dea						
		Prince George			Cheverly			ce George's					
Funeral Director		5. Social Security Number 6. S 226–34–6194	ex 7. Age (In yrs. last birtho	Months Davs	If Under 24 Hrs Hours Min.		Year)	othplace (State or Foreign Country) oth Carolina					
pu s		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town o	r Location				10d. Inside City Limits					
taryle sho	J.							1 AYes 2 No					
the M	Directo	Maryland Prince	George's	10f. Zip Code	estville		0g. Citizen of What C	Country?					
with a or		1108 Waterf	ord Drive	Tor. Zip Code	20747			l States					
leath	era	11. Marital Status	· · · · · · · · · · · · · · · · · · ·	13. Was Decedent of H		Specify Yes or No-	14. Race - Am						
NE, Maryland 21215-0036 stand 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Itam 27 is marked other than "natural; or items 23a or 28a-f show other traumatic avent, in a Modeal Examination at the notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of Hold of It Yes, specify Cub. 1 ☐ Yes 2 XNo	an, Mexican, Puer Specity:	to Rican, etc.)	Black, Wh						
2 ho	Completed	15. Decedent's E	ducation 16a. D	ecedent's Usual Occup	ation		16b. Kind of Busines:	s/Industry					
P. P. P. P. P. P. P. P. P. P. P. P. P. P	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	Give kind of work done fe. DO NOT use retire	auring most of wo d)	rking	Washingto	n Post					
od will	Соп	12th		Superv	isor		Newspaper	•					
DC be fill d oth d oth	Be	17. Father's Name (First, Middle, Last,			18. Mother's Na	me (First, Middle, I							
Maryland d 2 should be file th and Mental Hy ?? Is marked oth traumatic avent	2	James Ta1  19a. Informant's Name/Relationship (		failing Address (Street	and Number or R		ha Wright	Zip Code)					
, Ma and 2 salth ar n 27 Is er trau		Bridget R. Ta		1108 Wateri				20747					
Saltimore, bernit. Pages 1 ar Department of Hea mportant: If item: any injury or other		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □  A □ Departure 5 □ Other (Sec.)	Removal from State cemetery,	isposition (Name of crematory or other place Memorial I		Date 27/2006	20c. Location - City o Landove						
Baltimor permit. Pages Department of I Important: If its any injury or o		*4 □ Donation 5 □ Other (Specification 21. Signatur 1 Fyrianal Service Licentation 21. Signatur 1 Fyriana Service 21. Signatur 1 Fyriana Service 21. Signatur 1 Fyri		22. Name and Addre			Funeral Ho	•					
<b>n</b> 88 <b>5</b> 8 8		John T.	Steward III				Wash., DC						
Pnysician		23a. Part 1. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line.  Immediate Calse (Final disease or contrion Septic Shock											
/Medical Examiner		a											
	ē.	Sequentially list conditions, if any, leading to immediate	b. Sepsis Gram I					days					
uted d ansit	Examiner	Cause (Disease or injury that initiated events	Metastatic pr	rostate car	ncer			years					
oa recuted icate be executed physician and sthe burial-transit	I Exa	resulting in death) Last	Due to (or as a consequence of).			-							
68 / 60, ficate be ex physician s the burial	edical		d										
death certifi e attending p d for use as	NA M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	• 🗆 =			23d. Date ol de	elivery					
. 0 00	Physiclan/Me	in the past 12 m <i>o</i> nths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 2□Fetal death 4□Pregnant at time <i>o</i> f death 9□Unknown	3 Ectopic pregnancy 5 Other (specify)	/		Month	Day Year					
	y Ph	Part II. Other significant conditions of	ontributing to death but not resulting in th	e underlying cause giv	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?					
ecords, P.O. law requires that the as been signed by th	ed by	Coronary	artery disease, H	ypertension	1,	1 □ Ye	es 2□No 3□F	robably 4 Unknown					
VITAI HECORDS, sician: The law requires t certificate has been signe irector, page 2 should be	Completed	Anaemia	of chronic disease	Hyperlip:	idemia	24a. Was a autops perform	y prior to ned? death?						
VITAI sician: T certificat irector, pi	a	25. Was case referred to medical			26. Place of De	ath (Check only on	71	s 2 No					
Of VITA Physician: rithis certific ral director,	OB	examiner? 1 □ Yes 2 □ <b>y</b> No	Hospital: 1 ☑Inpatient 2 ☐ ER/Outpa	atient 3 DOA Oth	05		ence 6 Other (Spe	ecify)					
IVISION OT r Attanding Physer death. rector: After this by the funeral d	tlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Tim	ry Wor			ow injury occurred	,,					
DIVISION  I or Attanding  I after death.  I Director: After  d in by the func	Certification;	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At home, farm building, etc. (Specify)	, street, lactory, office		28f. Location (St. City or Town	reet and Number or F n, State)	Rural Route Number,					
		29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam	ysician: To the best of my knowledge, d niner: On the basis of examination and/o	eath occurred at the tir	ne, date and place	e, and due to the ca	ause(s) and manner a	is stated.					
o the H ilthin 24 o the F omplete	Medical	29b. Signature and title of certifier	and manner stated.	29c. Licens			9d. Date signed (Mon						
F 3 F 8		· (a)/	Juitagimo		D24720		March 3	21, 2006					
1 /2)	į		completed cause of death (Item 23a) (Ty	pe, Print)	D24120	1.5	riai CII 2	.+, 2000					
7			Rustagi, M.D. 613	2 Landover	Road, Cl	neverly,	MD 20785						
Stat Registra		31. Date filed (Month, Day, Year)  MAR 2 4 2006	2. Registrar's Signature	•		-							

		1- For State of Maryland / Department of He Registrar Certificate of D		ental Hygie	and you you you	11271
est de	1.54	Decedent's Name (First, Middle, Last)		. Date of Death		3. Time of Death
Phys /Me	ician dical	Ruth Posey Turner		March 2	Day Year 2006	1:53P M
Exan		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or	Location of Death		4c. County of Death	ו
	48	Civista Medical Center La Plat			Charles	
Funer: Directo		5. Social Security Number 6. Sex 1 M 2 F 83 Yrs.  1 M 2 F 83 Yrs.	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, Ye	9. Birth Con	nplace (State or Foreign untry)
	ar T	Usual Residence of Decedent	IM	arch 25	5,1922 M	aryıand
yland how		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
e Ma	ctor	Maryland Charles Indian Head				1 XYes 2 No
ith th	Directo	10e. Street and Number 10f. Zip Code		10g.	Citizen of What Cor	untry?
ath w a 23a	2	9 Kenwood Place 2064			U.S.A.	
ter de	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 1 Yes 2 No	spanic Origin? (Specit n, Mexican, Puerto Ric	fy Yes or No- can, etc.)	14. Race - Amer Black, White	
J36 urs af	by F		Specify:		Specify: W	hite
Z1Z15-0U36 ad within 72 hours aff giane. er than "natural", or the Medical Exami	ted	15. Decedent's Education 16a. Decedent's Usual Occupa		16b	. Kind of Business/l	
thin 7	Completed	(Specify only highest grade completed) (Give kind of work done dulifie. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+)	)			
ed will	Sol	11 Retail Buyer			Store	
YIBING Z1Z13-UU35 build be filled within 72 hours after death with the Maryland Mental Hygiene. arked other than "natural", or Itema 23a or 28a-1 show attic event, the Medical Examinat must be to itiliad at	Be		18. Mother's Name (F			
aryla should? and Meni	10			. Bowl		7-0-11
Maryland d 2 should be file th and Mental Hy t7 is marked oth traumatic event						
BAIRTIMOTE, MATYIANG Z1Z15-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "natural", or Itema 23a or 28a-1 show any injury or other traumatic event, the Medical Examinations must be motified at					Location - City or 1	
Pages ant of nt: If I		20a. Method of Disposition  1	March 25	2006 <sub>-</sub>		
altimore, mil. Pages 1 ar partment of Hea portant: If Itam		21. Signature of Funeral Service Licenses 22. Name and Address	s of Facility			n, Marylar
	ā	M00668 William	s Funera wthorne	l Home,	P.A.	20640
PA COU.  Sate be executed hysician and hysician and the burnet-transit the burnet-transit the partial transit.	al	Due to (or as a consequence of):  Sequentially list conditions  b. A which is the sequence of	a, lura			Interval Batween Onset and Death
death certific e attending p	Physician/Medic	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  1  Unknown  23c. If yes, outcome of pregnancy 1  Temperature of the past 12 months? 1  Pregnant at time of death 5 Other (specify)			23d. Date of deliving Month	very Day Year
- c 2 m			n in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
w require been sig should b	ete	Pulmonary hypertension		24a. Was an		
lor Attending Physician: The law requires I after death.  Director: Atter this certificate has been signe in by the funeral director, page 2 should be	Completed by			autopsy performed	prior to c	topsy findings available ompletion of cause of 2 No
VIII siciar certif recto	Be	examiner:	26. Place of Death (C			
Phys or this	5.70	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other  27. Manner of Death 1 Month, Day Year) 28b. Time of Injury Work	4   Nursing Home	d. Describe how in	e 6 □Other (Spec	ify)
nding P th. : After e funera	tion		? /es 2 □ No		,	
Hospital or Attending Physician: Hospital or Attending Physician: Puneral Director: Atter this certifice tely filled in by the funeral director,	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f	f. Location (Street City or Town, St	t and Number or Ruitate)	ral Route Number,
To the Hospital or Attent within 24 hours after death to the Funeral Director: completely filled in by the	edical C	29a. Certifier (Check only one)  Certifying Physician. To the best of my knowledge, death occurred at the time (Check only one)  Certifying Physician. To the best of my knowledge, death occurred at the time (Check only one)	e, date and place, and inion, death occurred	d due to the cause at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the within 2 To the complet	₩	29b. Signature and little of certifier 29c. License	number	29d.	Date signed (Month	, Day, Year)
. , , ,		D-334	26		3-22-0	6
9		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)				
186		B. Larry Jenkins, MD 111 LaGrange Ave La Pla	ita. MD 200	546		
Regis	tate strar	31. Date filed (Month, Day, Year)  MAR 2 7 2006  MAR 2 7 2006	,	- 10		

	*		1 - For State Registrar	State of M	aryland / I	-	artment tificate			and M		Reg. No.	000		13	75
}	Physici /Medic Examir	cal	Decedent's Name (First, Middle, Charles     Charles     Aa. Facility Name (If not institution, g	Ε.	Thomp	soı			Location o		2. Date of Dea Month March	Day 24		06	3. Time of	. м
	Funeral Director		Union Hospita	1	ge (In yrs. last bi	rthday) Yrs.	If Under 1	ktc Year Days	If Under 2	Min.	8. Date of Birt (Month, Day	h y, Year)	Cec:	Birthpla Countr	ace (State o	r Foreign
	D	Funeral Director	Usual Residence of Decedent	AVenue  12. Was Decedent Armed Forces?	New	arl	10f. Zip 0	197	'-02 spanic Orig			10g. Citi	zen of What  USA  14. Race - A  Black, W	Countr	n Indian,	ty Limits
and 21215-0036	be filed within ital Hygiene. d other than "	Be Completed by	1 Never Married 2 Married 3 Note of Married 15 Decedent's (Specify only highest of Married) 8 17. Father's Name (First, Middle, La	ft Yes, Give Year or Dates: Education grade completed) College (1-4or:	16a	Deced (Give life. I	lent's Usual kind of work DO NOT use	Occupa done d retired)	Specify: Ition Juring most	of workir		16b. Ki	Specify: {  nd of Busine  Aut	Whi	te	
Baltimore, Maryland	permit. Pages 1 and 2 should be Department of Health and Mental Importent: If item 27 is marked only injury or other traumatic evone.	То	Charles E. Th  19a. Informant's Name/Relationship  Kenneth Thomp  20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spe  21. Signature of Funer I Service In	(Type, Print) SON (SON) □Removal from State	20b. Place of comete Grace	213 f Dispo ry, crem 1 a V P a	B Gla sition (Name natory or oth In Me ark . Name and	SGO e of ner place MOT	w Av	enue 3/: Bee	llen I Route Numbe New 28/06 eson F nway,	r, City of 20c. Lo N une	cation - City  ew Caral F	or Tow ast Hom	197 m, State le, l	
8760,	Late be executed / Medical Examiner and pural-transit the burial-transit	lical Examiner	23a. Part1. Enter the disease, or or shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as	a consequence	of):  Of):	er the mode	of dying	g, such as o	cardiac o	respiratory ar	rest,		1	Approximate nterval Betv Onset and E	ween
.O. Box 6	death certifi e attending I id for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death		Ectopic pred Other (spec					2	3d. Date of o	,	'	'ear
S, D	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions	contributing to death b	ut not resulting i	n the ur	nderlying cau	use give	n in Part I.			es 2	se contribute		cause of de	
Vital Record	The ate his page	e Completed	25. Was case referred to medical						26 Place	of Death	24a. Was a autop perfor 1 Yes	med? No	24b. Were prior to death	to comp	sy findings a pletion of ca	ivailable luse of
of	ding Phys h. After this funeral di	To B	examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigal	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	ry 28b.	utpatien Time of Injury	t 3□ DOA 28	c. Injury Work	r: 4□ Nur	rsing Horr	e 5 Resid	ence 6		pecify)		
Division	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	Certification;	3 Suicide 6 Could not determine	building, et							Bf. Location (S City or Tow	n, State)				7er,
	To the Hospitel within 24 hours a To the Funeral completely filled	Medical	(Check only 2/1 Madical Ex	Physician: To the best miner: On the basis o and manner st	f examination ar	e, death nd/or inv	estigation, i	n my op	e, date and inion, deat number	d place, a h occurre	d at the time, o	late and	place, and d	lue to th	he cause(s)	
	To CO		> / Hou	, ~			0	54	073	>	1	27	MA2 O	6		
4	HIVA		1-1-	o completed cause of c	death (Item 23a)	(Type,	E HANG	-	CTI	- 1	YEWGA	576	DE	15	720	
	Sta Registr	ite ar	31. Date filed (Month, Day, Year). MAR 2 9	2006 32. Figistr	ar's Signature	1	perte	,								

			1 - For State Registrar	State of M	aryland	/ Depa		of Healt	h and M	•		006	11376
			1. Decedent's Name (First, Middle, Las	t)						2. Date of De		0 0 0	3. Time of Death
	Physici /Media		Mildred Leota	Thorne						Marc	h 3%	2, 200 i	6 1040 M
di .	Examir		4a Facility Name (If not institution, give			i	4b. City. To	wn, or Local	ion of Death			County of Dea	
				ice att	he Co	rko	Sa	lisk	ary	<u>'                                      </u>	- (	Mie	omico
	Funeral		5. Social Security Number 6. Se	9x 7. Ag □M 2 <b>X</b> F	ge (In yrs. las	t birthday) Yrs.	If Under 1 Months D	Year If Un Days Hou	nder 24 Hr.	8. Date of Bir (Month, Da	iy, Year)		thplace (State or Foreign ountry)
	Director		214-12-4379 Usual Residence of Decedent		94	115.				Sept.	12, 1	911 M	aryland
	yland		10a. State 10b. County		10c. City, 1	Town or Lo	cation					~~~	10d. Inside City Limits
$\bigcirc$	Mar Med	io	MD Dorches	ster			Cau	mbridg	je				1 ⊠Yes 2 □ No
Z	ith the	)Ire	10e. Street and Number			-	10f. Zip Co				10g. Citiz	en of What Co	ountry?
3	ath w	Funeral Director	210 Henry St.					216				USA	
0	er de	E E	11. Marital Status	12. Was Decedent Armed Forces?	)	13.	Was Deceden f Yes, specify	nt of Hispanio Cuban, Mex	: Origin? (Sp. kican, Pu <i>e</i> rto	ecify Yes or No Rican, etc.)	1	<ol> <li>Race - Ame Black, White</li> </ol>	
36	rs aft	by F	1 Never Married 2 Married 3 Moder Married 4 Divorced	1 ☐ Yes 2 🔀 I If Yes, Give Year or Dates:	No		1 ☐ Yes 212	¶No Spe	cify:		3	Specify: W	hite
21215-0036	72 hours after death with the Maryland naturel; or items 23a or 28a-f show Alcel Examirat must be notified at	ted.	15. Decedent's Ed	ucation	1	16a. Dece	dent's Usual (	Occupation			16b. Kin	d of Business	/Industry
215	within 7; ene. then "n	Completed	(Specify only highest grad	de completed) College (1-4or 5	5+)	(Give life	kind of work of DO NOT use	don <i>ë during :</i> retired)	most of work	ing			,
2	filed withi Hygiene. Ither ther	Son	11		,		homema	aker				own h	ome
Maryland	4 ta 50	Be	17. Father's Name (First, Middle, Last)					18. M	lother's Name	e (First, Middle,	Maiden S	Sumame)	
Z		မ	Oscar Lyons						Nora C				
Mai	s 1 end 2 should f Health and Mer itsm 27 is marke other traumatic		19a. Informant's Name/Relationship (7)							al Route Numbe	7200		Zip Code)
	s 1 end if Heall itsm 2 other		Frank C. Thorne J	Jr. son	20b. Plac	e of Dispo	sition (Name	of		isbury,		21804 ation - City or	Town, State
Baltimore,	0 0		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cem	ietery, crer	natory or other Memor	er place)	  ark 11	1/06		bridge	
量	in je arti		21. Signature of Fineral Service Fine		DOTCI		. Name and			homas I			
B	Dep imp		I the will	~~			700 Loc	cust S		mbridge			
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	dications that caused	d the death.	Do not ent	er the mode o	of dying, such	as cardiac	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	/ / /	110.	1-	A	ude	-				Onset and Death
	/Medical		resulting in death)	a	a consequer	nce of):		une	<del>-</del>				Won   - (
	Examiner		Sequentially list conditions,	b									
	sit sit	iner	rany, leading to immediate cause. Enter Underlying	Due to (or as	a conseque	ice of).							
	and I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	a consequen	nce of):							
68760,	death certificate be executed e ettending physicien and ad for use as the burial-transit	ical E			2 3011034301	100 01).							
687	ficate p phys is the			d									
Box	ath certifica ntending ph or use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23	3d. Date of de	iverv
m.	death e ette d for	icia	in the past 12 months? 1 □ Yes 2 No	1 ☐ Live birth 4 ☐ Pregnant at			Ectopic pregi Oth <i>er (speci</i>					Month	Day Year
P.O.	that the de sed by the e deteched i	hys	9 ☐ Unknown	9□ Unknown									
	law requires that the as been signed by th 2 should be deteche	by F	Part II. Other significant conditions co	ntributing to death b	ut not resultir	ng in the u	nderlying caus	se giv <i>e</i> n in P	art I.	23e. Did to	obacco us	e contribute to	the cause of death?
S.d	w requir been si should				·					10'	Yes 2	<b>11</b> 10 3 □ Pi	obably 4 Unknown
Records,	e law r has be je 2 sh	Completed								24a. Was			itopsy findings available completion of cause of
	Th ate	S								perfq 1 ☐ Yes	rmed?	death? 1 ☐ Yes	4
Vita	sician: Th certificate irector, pag	Be	25. Was case referred to medical examiner?	Hospital:				7	lace of Death	Check only d	ine)		
of Vital	Phys this ral dii	7	1 Yes No	28a. ate of Inju	ent 2 ER	VOutpatien 3b. Time of		<del></del>		me 5 ☐ Resid 28d. Describe h			cify)
O	Attending Phir death. ector: After thiby the funeral	tion	Natural 5 Pending 2 Accident investigation	(Month, Da	y Year)	Injury	м 200.	Injury at Work? 1 ☐ Yes 2		zod. Describe i	iow injury	occurred	
Division	or Attendi after death. Director: A in by the fu	fica	3 Suicide 6 Could not be	288. Place of Inj	ury - At home	e, farm, str	eet, factory, o			28f. Location (S	Street and	Number or Ri	ural Route Number,
ă	s after s after ni Dire	Certification:	4   Homicide	building, et	c. (Specify)					City or Tov	vn, State)		
	To the Hospital or Attenwithin 24 hours after deation to the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)  Certifying Phy 2 Medical Exam	ysician: To the best iner: On the basis of and manner sta	of my knowle f examination ated.	edge, death n and/or inv	occurred at trestigation, in	the time, date my opinion,	e and place, death occurr	and due to the ed at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To the vithin 2 To the complet	Me	296. Signature and title of certifier	///			29c. L	icense numb	ner ne		29d. Date	signed (Mont	h, Day, Year)
			LAKE	W.	M		L	160	278		3	-28	-06
			30. Name and address of person who c	. 0/	leath (Item 23	3а) (Туре,	Print)	Pa. 17	25	(41.1		11	11902
	Sta	to.	31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	os pre	POI	OUX / /		09/180	7		-1
	Registr		MAR 29	ZUUD MI	alues.	K.	boots	9					
DH	MH 17 Rev 1/20	001		7-0			7						

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of I	Maryland / Dep <i>Ce</i>	artment of F ertificate of			iene	6	11377
	Dhoois		1. Decedent's Name (First, Middl	e, Last)				2. Date of Deat	h		3. Time of Death
	Physici /Medio			Olive Thie	ssen			March	24 200	06	8:15 P <sup>M</sup>
	Examir	ier	4a. Facility Name (If not institution	n, give street and number	er)	4b. City, Town, o	or Location of De	eath	4c. County of Death		
			Howard County (		<u> </u>	Colum			Hov	vard	
	Funeral		5. Social Security Number	6. Sex 7. 1 ☐ M 2 🛣 F	Age (In yrs. last birthday	Months Days	If Under 24 H Hours M	in. (Month, Day,	Year)	9. Birthp	place (State or Foreign
	Director		Usual Residence of Decedent		95 Yrs.			Apr 12,	1910	New	York
	land ow		10a. State 10b. County		10c. City, Town or L	ocation				1	Od. Inside City Limits
	Mary Fred	ţ	MD Hov	ward	Ellicot	t City					1 ☐ Yes 2 🛣 No
	r 28s	<u>le</u>	10e. Street and Number	valu	LITTOU	10f. Zip Code		10	g. Citizen of V	Vhat Cour	ntry?
	h wit	a D	3004 N. Ridge H	Road #602		21043			United		
	dea	Funeral Director	11. Marital Status	12. Was Decede Armed Force	ent Ever in U.S. 13.	Was Decedent of H	Hispanic Origin?	(Specify Yes or No-	14. Race	- Americ	an Indian,
စ္တ	filed within 72 hours after death with the Maryland Hygiene. thar then "nettrel", or items 23e or 28e-1 show ont, the Mudical Examinat must be invilled at	Fu	1 ☐ Never Married 2 ☐ Marr	ned 1 Yes 21		If Yes, specify Cub  1 ☐ Yes 2 ☑ No	an, mexican, Pu	erto Hican, etc.)		k, White,	etc.
Ö	urel',	d by	3 Widowed 4 □ Divorced	Year or Date	es:	10 103 2 2 110	Зреспу.		Specify	Whi	.te
5	"net	Completed		it's Education st grade completed)	(Giv	edent's Usual Occup kind of work done	during most of w	vorking 1	6b. Kind of Bu	siness/Inc	Justry
7	withir and the then	Ę,	Elementary/Secondary (0-12)	Coilege (1-4d	or 5+)	DO NOT use retire	d)				
0 0	filed Hygi thar	ပ္သ	17. Father's Name (First, Middle,	Last)	Te	acher	18 Mother's N	lame (First, Middle, M	Educa		
an	ld be ental kad o	To Be	John Tuttle	,				ouise Lync		<del>u</del> )	
Maryland 21215-0036	and Marks marks	-	19a. Informant's Name/Relations	hip (Type, Print)	19b. Mail	na Address (Street		Rural Route Number,		State Zin	Code
	s 1 and 2 should be filed within 72 hours after death with the Manylan if Heatth and Mental Hygiene. Item 27 is marked other then "neturel", or items 23e or 28e-1 show other treumetic event. It is Medical Examities in intelligible in Milled at		Anne Thiessen/D					Catonsvill			
Baltimore,	as 1 a of He of He fitem		20a. Method of Disposition		20b. Place of Disp	osition (Name of matory or other place	(a)	Date 2	Oc. Location -	City or To	wn, State
Ĕ	permit. Pagas Department of I Importent: If it any injury or o		1 ☐ Burial 2 【 Cremation `4 ☐ Donation 5 ☐ Other (S		Metro C		´ I	27-2006	Catonsv	rille	. MD
ä	aparti aport ny inj		21. Signature of Funeral Service	Licensee P 6							ly FH Inc.
	2012	l III	I The Citt	- Wight				a Pike Ell:		ity,	MD 21043
	Physician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause on each	sed the death. Do not en inline. FROS CLEMING	ter the mode of dyir			st,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	a	as a consequence of):		OV DAIL	<i>p</i> .3.43.			7 His
	Lxammer	_	Sequentially list conditions,	b							
	ped Isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Exter or delying Cause (Disease or injury that initiated events	Due to (or a	as a consequence of):						
•	ficate be exacuted physician and is the burial-transit	xan	that initiated events resulting in death) Last	c. Due to (or a	as a consequence of):					-	
8/60	s be e	dlcalE									
ρg		0		d.							
X P P	at the death cartific i by the attending p etachad for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnancy				23d. Date	of delive	rv
	death e atten	icia	in the past 12 months? 1 ☐ Yes 2 🙀 No	4☐Pregnant	at time of death 5	]Ectopic pregnancy ] Other (s <i>pecify)</i>			Mon		Day Year
j.	at the by the	hys	9 Unknown	9□ Unknown							
ń	gnec oe de	by F	Part II. Other significant condition	ns contributing to death	but not resulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contri	bute to th	e cause of death?
Cord	w requir been si should I	ted						1 ☐ Yes	2 No :	3 🗀 Proba	ably 4 □Unknown
ပ္	aw as b	ompleted						24a. Was an autopsy	24b. W	ere autop	psy findings available appletion of cause of
	ate pag	Co						performe	ed? de	eath?	2 <del>Syl</del> No
VII	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hamitali				eath (Check only one)			
5	hys this al di	5	1 ☐ Yes 2 ☑ No 27. Manner of Death	Hospital: 1 Inpa			4 Li Nursing	Home 5 Residen			)
	After After fune	ertification	1X Natural 5 ☐ Pending		njury 28b. Time o Day Year) Injury	Worl	/at <br Yes 2 □ No	28d. Describe how	injury occurre	d	
20	l or Attending after death. Director; After i in by the fune	fica	3 ☐ Suicide 6 ☐ Could n	not be	njury - At home, farm, str		165 2 110	28f. Location (Stre	et and Numbe	r or Bural	Pouto Number
5	after after Dire d in b	erti	4  Homicide determi	building,	etc. (Specify)	oot, labiory, office		City or Town,	State)	or riorar	riodia ivaniber,
	To the Hospitel or Attent within 24 hours after death To the Funeral Director; completely filled in by the	calC	29a. Certifier (Check only 2 Medical E	g Physician: To the bes	st of my knowledge, deat	occurred at the tim	ne, date and place	ce, and due to the cau	se(s) and man	ner as sta	ited.
	the H in 24 the F the F	ledical		and manners	of examination and/or in stated.	vestigation, in my or	oinion, death occ	curred at the time, date	e and place, ar	nd due to	the cause(s)
ı	with To	Σ	29b. Signature and title of certifier	7		29c. License		290	I. Date signed	(Month, E	ey, Year)
$\overline{}$	2	-		Mo			1860	N	March 2	7, 20	)06
6	0		30. Name and address of person v		f death (Item 23a) (Type,	Print) O CHARTER	DAIVE	# 200 Cocu	MBIA M	0 21	44
D	Stat	te	31. Date filed (Month, Day, Year)	32. Reals	strar's Signature		bi-i- E	71 0 - 0 - 30			
	Registra	ar	MAR 2.8	3 SUUE	Burn H	hack .					

Robin Thompson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06 - 2230Unpend item#23a,27, perME 9854,4/24/06 TT Department of Health and Mental Hygiene AKG 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Robin Leon Thompson 31, 3:53 P March 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 20552 Spring Hill Road Lexington Park Saint Mary's If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral №** м 2□ F Months Days Hours Yrs. 213-92-6827 44 03/01/1962 Washington DC. Director Usual Residence of Decedent Manyland 10c, City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28a-f show rthan "natural, or itams 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2♥ No Lexington Park Maryland St. Mary's Direct the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20653 United States 20552 Spring Hill Road Funeral filed within 72 hours after deeth 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) i Hygiene. other then Food Chef 12 permit. Peges 1 and 2 should be filed v Department of Health and Mental Hygie Important: if Item 27 is marked other till any injury or other traumatic avant. Ill pncs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Ann Thompson Harold Wenden Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 49671 Airedele Road Ridge, Maryland 20680 Jason David Thompson / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre 04/05/2006 Charolette Hall, MD. 22. Name and Address of Facility Brinsfield Funeral Home PA. 21. Signature of Funeral Service Licensee Kyle S. Simons M01206 22955 Hollywood Rd. Leonardtown, MD. 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclerotic cardiovascular disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Attanding Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the e should be detached f Division of Vital Records, P.O. 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ✓ es 2 □ No 1X Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other:  $_{4} \square$  Nursing Home  $_{5} \square$  Residence  $_{6}$  NOther (Specify) at Scene Hospital: 1⊠Yes 2□No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide ō 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title certifie

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4

32. Registrar's Signature

1400m

5 2006

12.

31. Date filed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, Maryland

April 1, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 8 Per Infor. gc,4/6/06 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Whibley Esther В. March 26, 2006 10:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country)
 Kansas 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2**XX**F Vrc 86 Director 510-14-2806 Aug. Usual Residence of Decedent Pages 1 end 2 should be filled within 72 hours after deeth with the Maryland nent of Heatth and Mental Hygiene.
ant: If Item 27 is marked other than "naturel", or Items 23a or 28a-f ehow ury or other treumatic event, the Medical Examinar must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Silver Spring Maryland Maryland Montgomery 1 Yes 2XXNo Completed by Funeral Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 20906 USA 4 Broomall Court 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2/2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3√XXVidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1 Self-Employed yr. Printer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Margaret Zickefoose J. Lee Byram ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 Saddle Ridge Circle Rockville, Maryland 20850 Star Kremonas / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. March 30, 2006 Cheltenham, Maryland 4 Donation 5 ☐ Other (Specify) Maryland Vet. Cemetery 21. Signature Funeral Service Licensee 22. Name and Address of Facility 22. Name and Address of Facility George P. Kalas Funeral Home PA 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gays e on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Direumani CI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitei or Attending Physician: The law requires thet the death certificate be executed ettending physicien end for use as the burial-transit Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a Was an 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending s after oc. el Director: Atr 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitei c within 24 hours af To the Funerei D completely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29b. Signature and title of certifier & FLSdy42C 00062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5040 M - ELSO440 9715 MCa Medita Center Dr. Rockwille MD 20850 State

DHMH 17 Rev 1/2001

Registrar

MAR 2 9 2006

			1 - For State Registrar	State of Maryland	d / Depa		Health and	Mental Hyg	iene	6	38	3 0
44			Decedent's Name (First, Middle, Las	t)				2. Date of Deat	h	·	3. Time of D	Death
1	Physici /Medio		Anglo Stanley	Williams, Jr.				March		Year 006	0030	М
4.	Examir		4a. Facility Name (If not institution, give			4b. City, Town	, or Location of Deat	h	4c. County of	f Death		
		A.	Prince George's				Chever1y		Pr		George	
€	Funeral Director		5//-28-1430	9X 7. Age (In yrs. ia ■ XM 2□ F 81	Yrs.	if Under 1 Ye Months Day		8. Date of Birth (Month, Day, July 11			lace (State or try) aryland	
	aryland show	2	Usuat Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ocation				1	0d. Inside City	
	ier deeth with the Marylar items 23s or 28s-f show rect must be notified at	Director	Maryland   Prince (	George's		Seat 10f. Zip Code	Pleasant	10	Og. Citizen of W	itizen of What Country?		
	ath w	<u>e</u>	7012 Greig C				20743				States	
	er de	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of If Yes, specify C	of Hispanic Origin? (S uban, Mexican, Puer	pecify Yes or No- to Rican, etc.)		<ul> <li>America</li> <li>White, a</li> </ul>	an Indian, etc.	
0036	72 hours after deeth with the Maryland natural', or Items 23a or 28a-f show disal Examinat must be notified at	5	1 ☐XVever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2X ☐ No If Yes, Give Year or Dates:		1□Yes 2□XN	2 11 12 12		Specify:		lack	
Maryland 21215-0036	J within 72 hours after jiene. r than "natural", or litter Medical Examin	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)		16a. Dece (Give life.	dent's Usual Occ kind of work doi DO NOT use ret	cupation ne during most of wo ired)	rking	16b. Kind of Bus	iness/Inc	dustry	
12	i Hygier other ti		6th 17. Father's Name (First, Middle, Last)			Cust	todian	me (First, Middle, N		ivat	:e	
anc	Q 2 2 2	Be		Udilliana Cr			to. Mother's Nat		oeth Gas			
Ž	should be nd Menta marked umatic ev	은	19a. Informant's Name/Relationship (7	Williams, Sr.	19b. Maili	na Address (Stre	eet and Number or Ri					
	nd 2 :		Barbara J. Joyn	•			no St., Se			207		
ore			20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	1 00	ace of Dispo	osition (Name of matory or other p	place)	Date 2	20c. Location - C	ity or To	wn, State	
Ē	nit. Pages eartment of lortant: if its ortant: if its injury or of		4 ☐ Donation 5 ☐ Other (Specify	) Harm		emoria1		1/2006	Lando		MD	
Baltimore,	permit. Page Department of Important: if any injury or		21. Signature of Funeral Service Licen	Twood II	2		dress of Facility S l Benning	tewart Fu Rd., N.E.			20019	
	Pnysician /Medical Examiner	Iner	23a. Part1. Effer the disease or companies, heart failure. List only of immediate C. se (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	a. Abdominal A  Due to (or as a consequence)  Bus to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	ortic ence of):			c or respiratory arre	st,		Approximate Interval Betwi Onset and De	reen
). Box 68760,	the death certificate be executed by the attending physicien and tched for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{No} \)	c	ncy death 3[	Ectopic pregnal			23d. Date Moni		ry Day Ye	ear
s, P.O.	es thet the de igned by the a be detached t	by Phy	9 ☐ Unknown  Part II. Other significant conditions or		lting in the u	nderlying cause	given in Part I.	23e. Did tob	acco use contril	oute to th	e cause of dea	ath?
ord	w requir been si should	ted	Urosepsis	<b>S</b>				1 🗆 Ye	s 2□No :	Prob	ably 4 □Un	nknown
Vital Records,	e la has	Completed	Dehydrati	on Obstructive Pul		Di		24a. Was an autopsy perform	pr ned? de	ere autor for to con ath? Yes	osy findings av npletion of cau	variable use of
ita	sician: Th certificate rector, pag	Bec	25. Was case referred to medicat examiner?	obstructive rui	monar	y Diseas		ath (Check only one	7			
on of V	Phys this ral dii	မ	t ☐ Yes 2 ♣No  27. Manner of Death 1 ♣Naturat 5 ☐ Pending	Hospital: 1 Inpatient 2 Inpati	R/Outpatier 28b. Time o Injury	f 28c. In		ome 5 Reside			)	
Division of	l or Attending after death. Director: After in by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify,	ne, farm, st		□Yes 2□No	28f. Location (Str. City or Town	on (Street and Number or Rural Route Number, Town, State)			
	Hospitel 4 hours Funerei tely filled	edical Ce	Check only one)	nician: To the best of my know iner: On the basis of examinati and manner stated.	/ledge, deat on and/or in	recoined at the vestigation, in m	time date and place y opinion, death occu	l , and due to the ca urred at the time, da	use(s) and man ite and place, ar	ner as et nd due to	the cause(s)	
	To the within 2 To the complete	Me	29b. Signature and title of certifier			29c. Lice	ense number	29	d. Date signed	(Month, I	Day, Year)	
)			Prus	Eran M	D		D0057636		March	26	2006	
,	(2)		30. Name and address of person who o			Print)	טכטוכטע		11al CII	209	2000	
_	0		Patricia Fh			ital Dri	ive, Cheve	rly, MD	20785			
	Sta Registr		31. Date filed (Month, Day, Year) MAR 2 8 2006	2. Registrar's Signati	are do	W.						

				For State Registrar		State of	Marylan	•	rtment of l ificate of				iene		1138	3
			4	Decedent's Name	(First, Middle, Las	st)	_				2.	Date of Deal	th Day	Year	3. Time o	f Death
		Physici /Medic		Jos	EPH	ROLAN	D	WARD	SR.			3	24	06	3:3	0 PM
		Examin		4a. Facility Name (If	-		•		4b. City, Town,		of Death			ounty of Deat		
	4				C GENERA			1 - 1 1 2 ab 4 - 1		LIN	24 Hee 1 o	0.1(0).1		ORCEST		
	Е	. Funeral Director		5. Social Security Nu 212-28-15	79	ex M 2□F 7	Age (In yrs. 78	Yrs.	Months Days		Min. DE	Date of Birth (Month, Day EC. 13	Year) 192	9. Birt Co 2.7 MA	hplace (State untry) .RYLAND	or Foreign
		and w		Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	y, Town or Loc	ation						10d. Inside C	ity Limits
		f sho	ō	DELAWARE	SUSSEX			SELBYVI								2 X No
		28a	Director	10e. Street and Nurr					10f. Zip Code			1	0g. Citize	en of What Co	untry?	
		death with the Maryland rms 23c or 28a-f show r must be notified at		37220	SAND DOL	LAR LANE			199	75				USA		
		deat sms	by Funeral	11. Marital Status		12. Was Deced	ent Ever in U	.S. 13. W	as Decedent of Yes, specify Cut		rigin? (Specif	y Yes or No-	14	I. Race - Ame Black, White		
9	98	72 hours after natural', or Ite	F	1 Never Marrie		1 TX Yes 2	□No		□Yes 2X No			an, 5(5.)	5	annifu.		
194/300C	21215-0036	ural',	d b	3 Widowed			es: 2/46	1						WH	ITE	
3	-5-	"nat	Completed		15. Decedent's Ed ify only highest gra	de completed)		(Give k	ent's Usual Occu ind of work done O NOT use retire	ipation e <i>during m</i> o ed)	st of working		16b. Kind	of Business/	industry	
#	112	within iene.	шо	Elementary/Secor	ndary (0-12)	College (1-4	tor 5+)		LICE OF				LAW	ENFORC	EMENT	
70		filled I Hyg other	Be C	17. Father's Name (	First, Middle, Last,						ner's Name (F					
	<u>la</u> u	uld be Menta rked tic ev	To B	JOSEPH		R.	WARD	1		BF	ERTHA		HA	YES		
00	Maryland	s 1 and 2 should be filled within 72 hours after death with the Marylan f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23c or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Na	me/Relationship (	Type, Print)		19b. Mailing	Address (Stree	t and Numi	ber or Rural R	oute Number	; City or	Town, State, 2	Zip Code)	
		and 2 ealth n 27 i			WARD/WI	FE			SAND DO	LLAR						
000	ore	of H	1 8	20a. Method of Disp	osition Cremation 3	]Removal from S	ate		atory or other pla		Date		20c. Loca	ation - City or	Town, State	
2	Ë	Pag tment tant:		` 4 ☐ Donation	5 Other (Specif	y)	SUI		MORIAL 1			06	BERI	LIN, MA	RYLAND	
	Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra 2002.		21. Signature of	neral Service Licer	1 See	was to	-	Name and Addr STINGS F		-	, SELE	BYVIL	LE, DE	. 1997	5
		¥		23a. Part1. Enter the	ne disease, or com nt failure. List only	plications that car	used the deat	. Do not ente	r the mode of dy	ing, such a	s cardiac or re	espiratory arr	est,		Approxima Interval Be	te tween
		Physician	9	Immediate Cause (	Final	1111		cence	1						Onset and	Death
2		/Medical		resulting in death)	(	Due to (o	as a conseq									
3		Examiner		Sequentially list cor	nditions,	b										
-125		ed sit	ine	cause. Enter Under Cause (Disease or	rtying	Due to Lo	r as a conse	nence of h								
50		ficate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) L		c. Due to (o	r as a conseq	uence of):						_		
عن	68760,	sician buria	ai			d										
رتع	687	ificate g phy as the	edicai			- U.										
-	Вох	death certiff e attending id for use as	Physician/M	IF FEMALE: 23b. Was decedent		23c. If yes, outc	ome of pregnath 2 Peta		Ectopic pregnan	~,			23	d. Date of del	•	
0	. B	ne deat the att	sicia	in the past 12 1 ☐ Yes 2 ☐			nt at time of c		Other (specify)					Month	Day	Year
7	P.O	by tac	Phy	9 Unknown								on- Dida-	حالت			2
0	<u>0,00</u>	res tha signed I be de	by	Part II. Other signifi	icant conditions (	contributing to dea	iin but not res	uiting in the un	derlying cause g	iven in Pan	( ).				the cause of obably 4	
3	700	v requires been sign should be	etec						<del></del>							
30	Sec	e lav	Completed									24a. Was a autops perfor	SV	prior to death?	topsy findings completion of a	cause of
12-	a	ician: Th certificate rector, pag		05 W/ss ssss								1 ☐ Yes	2 🗆 🛪 6		2□ No	
100	.0. <del>5</del>	ysician: is certific director,	o Be	25. Was case referrexaminer?		Hospital:	nationt 2	ER/Outpatient	30004 0		ce of Death (C			□Other (Spe	nifu)	
0.	٥.	두 등 등	I-	27. Manner of Death		28a. Date of	Injury	28b. Time of	28c. Inju			d. Describe h			city)	
3	<u>ე</u> ნ	2 = : 0	atio	1 ☐ Natural 2 ☐ Accident	5 Pending investigatio		, Day Year)	Injury	M 1	onk? ∐Yes 2[	□No					
5		after des Director	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 □ Could not b determined	200. Flace (	of Injury - At h		et, factory, office	9	28f	Location (S City or Town	treet and n, State)	Number or Ru	ıral Route Nur	nber,
<b>→</b>	<u></u>	urs afte			7		- 3	1 3 3								
		To the Hospital or At within 24 hours after CTo the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)	1 ☐ Certifying Pl 2 ☐ Medical Exa	nysician: To the bar miner: On the bar and manni	sis of examina	wieage, death ition and/or inv	estigation, in my	time, date a opinion, de	and place, and eath occurred	at the time, d	ause(s) a late and p	na manner as place, and due	stated. to the cause(	s)
		To the 7 within 2 To the complei	Ž	29b. Signature and		/_		D		nse number				signed (Mont		
		18/18		30. Name and address 20 5 0	ess of person who	completed cause	of death (Iter	n 23a) (Type, I	Print)	770	200	R	000	73/0	6	
	_	11/1							TECCIA	wig						- 0.7
		Sta Regist	ate rar	31. Date liled (Mon	th, Day, Year) MAR 2 8 1	2000	gistrar's Signi	ture A	ant.							
						1		~ M								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician**  $\tilde{23}$ 2115 MARCH 2006 WEBB VIRGIL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner BERLIN WORCESTER ATLANTIC GENERAL HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, MAY 13, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1X M 2□ F MARYLAND 1910 95 214-12-6785 Director Usual Residence of Decedent 10c. City Town or Location 10d Inside City Limits 10a State 10b. County r than "nsturs!", or items 23e or 28a-f show the Medical Examiner must be notified at 1 TYPS 2 NO WORCESTER SHOWELL MARYLAND Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 10035 PITTS ROAD 21862 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE ģ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) NURSERY FARMER 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Mental 1 and 2 should be MAMIE NICHOLS WEBB JOHN Η. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health at Important: If Item 27 Is sny injury or other trau 8102 PINE BRANCH ROAD, DELMAR, DE. 19940 VIRGIL L. WEBB/SON Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State REDMEN'S CEMETERY 3/27/06 SELBYVILLE, DE. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Juneral Service Licensee 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause ach line. Approximate Interval Between Qnset and Death Immediate Cause (Final heroselectu **Physician** peus. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) o 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown bluods Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performe 2□10 1 Yes 2 No certificate 1 Yes Division of Vital Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No After thi 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: Injury 1 Matural 5 [] Pending 1 Yes 2 No death. investigation 2 Accident Director: filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral ( Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature a me and address of person who completed cause of death (Item 23a) (Type, Print) S. (Cucles 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2 8 2006 Registrar

DHMH 17 Rev 1/2001

0

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** March 25, 2006 7:00 JO Whayland Teri /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico 3388 St. Lukes Road Salisbury If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3/5/1956 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🖾 F 50 212-66-1161 Maryland Director Usual Residence of Decedent 10d, Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar intant be confilled at items 23a or 28a-f show 1 Yes 2 No Director Maryland Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21804 USA 3388 St. Lukes Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Agent Building Supply 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joe Thomas Hornsby Annabelle McGrath 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Heather Lyn Groton/daughter 3388 St. Lukes Rd., Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Wicomico Memorial 3/30/06 Salisbury, MD \* 4 □ Donation 5 □ Other (Specify) Park 22. Name and Address of Facility Holloway Funeral Home Professional Association CFSP Dompon 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 1 hr ong disease or condition resulting in death) VS/ILL /Medical equence of): Due to (or as a o **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last oroma Due to (or as a consequence of) Examiner The law requires that the death certificate be executed **Durial-transit** Due to (or as a consequence of) Box 68760. Medical Certification: To Be Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy signed by the atte Month Day in the past 12 months' 5 Other (specify) Yes 2 No Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Donknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☑ No 2 No certificate 1 ☐ Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death / Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manney Death After 1 Tatural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide hours after within 24 hours are vithin 24 hours are / To the Funeral Dir 1 Certifying Physician. To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29h. Signature and title of certifier and HO2/8 who completed cause of death (Item 23a) (Type, Print) cas 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 2 8 2006

06-02359	
Whalen, Lana	

riease Type of Fillit ill black illuelible lilk				
State of Maryland / Department of Health and Mental Hygiene		200	1	
Certificate of Death	Rea No	Ca W W	U	

11384

Whalen, Lana	
	1- For State Registrar
Physician/	Decedent
Medical Examiner	Lana
	4a Facility
	O'Don
Funeral	5. Social Se
Director	219-0
	Usual Resid
£	10a. State

x ≥ 3 Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

Physici	_	1. Decedent's Name (First, Middle,Last)	1	2. Date of Death	110.	3. Time of Death
al Exami		Lana Jean Whalen		April 5, 2006	ay Year	21:01
		4a Facility Name (if not institution, give street and number)  O'Donnell Street ramp onto northbound I-  Baltimore	ocation of Death		4c. County of	Death
Funeral			If Under 24Hrs. Hours Min.	8. Date of Birth (	MM/DD/YYYY)	<ol><li>Birthplace (State or Fore Country)</li></ol>
Director		219-04-1512 1 M 2 X F 37 Yrs. Months Days	Hours Will.	April 28	3,1968	Wash., D.C.
ý		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limi
ow any						1 Yes 2 XI
yland a-f sh t once	tor	MD Baltimore Essex  10e. Street and Number 10f, Zip Code		100	Citizen of Wha	
e Mar or 28; ied a	Director		24	10 <b>g</b> .		r Godrid y :
vith the Maryland s 23a or 28a-f show a e notified at once.		19 Mooring Ct.  2122  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispa		ecify Yes or No-	USA 14 Race -	American Indian, Black,
r death v	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, N			White,	
ifter de	by Fi	3 Widowed 4 Divorced If year or Dates;	specify:		Specify:	White
Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygines at matter of the ment of Health and Mental Hygine at matter of the marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once or other traumatic event, the Medical Examiner	b D	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation during	n (Give kind of wo	ork done 16	6b. Kind of Busi	ness/Industry
n 72 h ian "n ical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) most of working life. DO NOT	T use retired)			
withi giene her th	mo	11 Waitress	Mothar's Name	(First, Middle, Mai	Restau	rant
ifiled all Hyge ed orl	Be C			eckliter	den Surname)	
should be filed with and Mental Hygiene 7 is marked other th natic event, the Med	.o.B	19a Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street a			r, City or Town.	, State, Zip Code)
2 sho h and 27 is	_	Raymond W. Lauer / father 1104 Pennypack	ker Lane	Bowie	, MD.	20716
l and Healt Fitem		20a. Method of Disposition  20b. Place of Disposition (Name of cemel	etery,	Date 2	Oc. Location - C	City or Town, State
Pages ent of nt: H		1 Burial 2 XCremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Metropolitan Cremat	ory 04/	08/2006	Alexan	dria. VA.
permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is injury or other traumat		21. Signature of Funeral Service-Licensee 22. Name and Address of		eall Fund		
in De		Chran Yould 6512 NW Cra			wie, MD	
nysician		23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, su failure. List only one cause on each line. Used and pools in injury, complications			shock, or hear	t Approximate Interv Between Onset ar
Medical kaminer		Immediate Cause (Final disease a. ethanol intoxication	ig cocame	and		Death
		or condition resulting in death)  Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
	ᆵ	cause. Enter Underlying Cause (Disease or injury that initiated c.				
ed	Examiner	events resulting in death) Last Due to (or as a consequence of):				
execular an and al - tra	ca	X UNPENDED X AMENDED item# 4a,23a,27,28a-f,perME.	0057. 7./10	5/06 TTP		
o certificate be executed ending physician and use as the burial - transit	cian/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	1,6054,4/1.	5/00 11	23d, Date of d	eliverv
ertifica ling p e as th	an/I	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3	Ectopic pregnar	ncy	Month	Day Year
attence or use		past 12 months?  4 Pregnant at time of death 5 Other (Specify) 9 Unknown				
To the Hospital or Attending Physician: The law requires that the death within 24 hours father death Tro the Funeral Director: After this certificate has been signed by the atta Completely filled in by the funeral director, page 2 should be detached for a	Physi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give	ven in Part I.	23e. Did toba	cco use contrib	ute to the cause of death?
s that gned le e deta	Ş					Probably 4 🗸 Unknow
equire een si ould b	ted			24a. Was an	24b. W	ere autopsy findings availat
law n has b	Completed			autopsy performe		ior to completion of cause o eath?
The ficate	S			1 ✓ Yes 2	No 1	✓ Yes 2 No
s certi	Be	examiner? Hospital: 4 Invalignt 2 FRIO testingt 3 DOA Ot	of Death (Check o	nlyone) gHome 5 Re	esidence 6	Other: Scene
g Physical thing eral di	<u>٩</u>	1 ✓ Yes 2 No 1 Inpatient 2 ERroutpatient 3 DOA  27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury 3				Subject exited
nding tth r: Af	Certification:	Natural 5 Pending 1 Yes	7/7/			e intoxicated
r Atte er dez irecto n by tl	fica	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office built	-	28f. Location (Stre	eet and Number	or Rural Route Number, C
ital ours affi	erti	Suicide  4 Homicide  Sould not be determined  (Specify) Major highway			e)O'Donne. altimore,	11 St. ramp to
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date	e and place, and			
o the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, d and manner stated.	death occurred at	t the time, date and	d place, and du	e to the cause(s)
F > F 0	ž	29b. Signature and title of certifier 29c. License r		2	9d. Date signed	d (Month, Day, Year)
		Cay of Hallan O.C.M.	1. E.	,	April 6, 2006	3
		30. Name and address of person who completed cause of death (Item 23a)				
		Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimor	re, MD 21201			
S Regis	tate	31. Date filed (Month, Day, Year)  32. Registrar's Signature				
17 Rev 1/2	2001	ORIGINAL				

DHMH 17 Rev 1/2001 OCME 10/2003

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		1 - For State Registrar	•	Department of Health and M Certificate of Death	Mental Hygien	411116	11385
Phys	sician	Decedent's Name (First, Middle, Las	"		2. Date of Death	ay Year	3. Time of Death
/Me	dical miner	Aa. Facility Name (If not institution, give	Jiagins, SR	4b. City.,Town, or Location of Death		1, 2006 S County of Death	3:53PM
		TRINCE George  5. Social Security Number  6. Second Security Number	e's Hospital Cent	thor Chevery  though If Under 1 Year   If Dode 24 Hrs.		Rince Co	place (State or Foreign
Funer Direct		249-42-3910	du one MII	Yrs. Months Days Hours Min.	8. Date of Birth Month, Day, Yea Kinuary	1932 500	th Carolina
yland Now		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	n or Location	3		10d. Inside City Limits
the Marylan 28a-f show	Director	D.C.	Wa	shington			1 Yes 2 □ No
036 ours after death with the Maryland est, or terme 23e or 28e-1 show	al Dire	10e. Street and Number 6 2 7 M 5	H. N.E.	107. Zip Code 2000 2	10g. C	Citizen of What Cou	intry?
a 2 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
		1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces?  1 X Yes 2 No 9-35-50  If Yes, Give Year or Dates: 7-15-54	1 ☐ Yes 2 DNo Specify:		Specify Afric	an-American
15-003 in 72 hours "naturel",	Completed	15. Decedent's Ed (Specify only highest grad	de completed)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	king 16b.	Kind of Business/fi	ndustry /
212 ed with ygiene.	Com	Elementary/Secondary (0·12)	College (1-4or 5+)	Engineer	D.	C. Bove	rnment
re, Maryland 21215-0036 s i and 2 should be filed within 72 hours alt Health and Mental Hygiene. Item 27 ie marked other than "natural", or other traumatic event, Ite Medial Exemi	To Be	17. Father's Name (First, Middle, Last)  UUKNOWN		Hôber Kôber	ne (First, Middle, Maide +a Wa	en Sumame)	
Aary 2 shou and M	-	19a. Informant's Name/Relationship (7		Mailing Address (Street and Number or Rui	ral Route Number, Sity	Town, State, Zi	ip Code)
Ta Lea		20a. Method of Disposition		Disposition (Name of y, crematory or other place)		002 Location - City or T	own, State
Pa Pa Pa Pa Pa Pa Pa Pa Pa Pa Pa Pa Pa P		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hamoval from State 6 Loan	tico National March		liangles 1	JA ,
Balt permit. Departr Importu	ODC	21. Signature of Juneral Service Licen	J. 22 2	22. Name and Address of Facility 2.	N. W. W.D	ASSIC, 10	ineral tome
NOTE:	6.0	shock, or heart failure. List only	lications that caused the death. Do none cause on each line.	not enter the mode of dying, such as cardiac			Approximate Interval Between Onset and Death
Physicia /Medic		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence	ock	~	-,	Onsot and Dogin
Examin		Sequentially list conditions,	. Ventilator	Dependent Kesp	itory tai	lure	
S uted ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events	legetative	State			
60, be executed iciden and burial-transit		that initiated events resulting in death) Last	Due to (fr as a consequence of	oral Hemmorage	0.		
587 587 ficate phys s the	ope		- Lillia Gerek	oral fieldinology			
Box 6 death certific e attending pod for use as	Physician/M	in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death			23d. Date of deliving	very Day Year
1/1 . 0 00	hysic	1  Yes 2 No 9 Unknown	4⊟ Freghant at time or death 9□ Unknown	5 Other (specify)			
N 8 58	۵	Part If. Dther significant conditions of	entributing to death but not resulting in	the underlying cause given in Part I,	23e. Did tobacco		the cause of death?
Record The law requir ate has been si	Completed				24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
	Be Co	25. Was case referred to medical examiner?			1 ☐ Yes 2 2 ↑ ↑ th (Check only one)	√o 1 □ Yes	2 No
O E = E		1 Yes 2 No 27. Magner of Death		ime of 28c. Injury at	ome 5 Residence		nfy)
Division of the death of the death of the the death of the the death of the the death of the by the tuneral at the pureral strick of the tuneral strick of tuneral strick of the tuneral strick of	catlor	Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No			
DIVI	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	28f. Location (Street City or Town, Sta		ral Route Number,
Division  To the Hospital or Attending within 24 hours after death. To the Funeral Director After completely filled in by the tuner	ledical C	29a. Certifier 1 Certifying Phy (Check only one)	rsician: To the best of my knowledge iner: On the basis of examination and manner stated.	, death occurred at the time, date and place, d/or investigation, in my opinion, death occur	, and due to the cause rred at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
To the within To the complex	Me	29b. Signature and tyle of certifier	1	29c. License number	29d. E	Date signed (Month)	. Day, Year)
an a	112	30. Name and address of person who	ompleted cause of death (Item 23a) (	D 27 5 7 7	03	122/0	76
ULU	IUI	OF HNELL CUMBE	RBATCH 3001 1		verly n	1 d. 20%	785
0.00	State istrar	31. Date filed (Month, Day, Year)  MAR 2 4 2006	2. Registrar's Signature	Soule	l		

RJ	01/04		Please	Chata of M					•		.egible.			
			1 - For State Registrer	State of M	aryıan	•	artment of <i>tificate o</i> f		id Mental Hy		106	11386		
			Registrer  1. Decedent's Name (First, Middle, La	uge)		Cei	uncate of	Dealli	2. Date of De		1 10 10	2 Time of Dooth		
	Physici	an	Roget Whitl	•					Month	Day	Year			
	/Medic		4a. Facility Name (If not institution, give	-			Ab City Town	or Location of E				-		
	Examir	ier	R. Adams Cowley S			nter		timore	Joann	40. 0	rounty or Dou			
	Funeral		5. Social Security Number 6.5	Sex 7. A		last birthday)	If Under 1 Yea	r If Under 24		rth (Cara)	9. Bin	thplace (State or Foreign		
	Director		578-84-8634	1 <b>X</b> 1M 2□F	44	Yrs.	Months Day	s Hours I	Min. (Month, D. Nov. 8	3, $196$	il Wa	sh., DC		
	P.		Usual Residence of Decedent		140-00									
	anyla •hov	_	10a. State 10b. County		Toc. City	y, Town or Lo	cation					~~		
	28a-1	Director	DC		<u> </u>		101 7:- 0-1-		nington	10- 0'4'-				
	tiled within 72 hours after death with the Maryland Hygiene. yther then "natural", or itema 23a or 28a-f ehow sht, the Medical Examinar most be medified at	늅	10e. Street and Number 4808 Alaba	-ma Azza	C F	#£ /4	10f. Zip Code	20019	a .		9. Birthplace (State or Foreign Country) 1961  10d. Inside City Limits 14 Yes 2 No.  Nog. Citizen of What Country?  United States  14. Race - American Indian, Black, White, etc.  Specify: Black  16b. Kind of Business/Industry  Private  Maiden Sumame)  Crice Ball  City or Town, State, Zip Code)  Oro, MD 20772  20c. Location - City or Town, State  Clinton, MD  Funeral Home  Wash., DC 20019  10d. Inside City Limits 12 Yes 2 No.  15 No. 10d. Inside City Limits 12 No.  16 No. 10d. Inside City Limits 12 No.  17 No. 10d. Inside City Limits 12 No.  18 No. 10d. Inside City Limits 12 No.  19 No. 10d. Inside City Limits 12 No.  10d. Inside C			
	na 23	Completed by Funeral	11. Marital Status	12. Was Decedent										
	tter d	뜶	1 Never Married 2 Married	Armed Forces	No				uerto Rican, etc.)		Black, Whit	e, etc.		
8	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I□Yes 2፟XIN	o <i>Specity:</i>		5	Specify: 1	ЗІаск		
9	72 ho	ted	15. Decedent's E (Specify only highest gr	ducation		16a. Deced	ient's Usual Occ	upation e during most of	f working	16b. Kind	Kind of Business/Industry			
2	ithin	npie	Elementary/Secondary (0-12)	College (1-4or	5+)	lite. I	00 NOT use retii	red)						
7	ed w ygier yer th	ပိ	10th				Laborer Pr				ite			
E I	be fill d off	Be	17. Father's Name (First, Middle, Last Herbert Wl					18. Mother's	•	*				
$\frac{2}{5}$	J Mer J Mer Jarke Jarke	ည				405 44-25-						7:- 0-4-)		
Maryland 21215-0036	d 2 sk th and 7 is n treun		19a. Informant's Name/Relationship (Ricardo Whitby/											
ė,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural; or itema 23a or 28a-1 ehow apprintly or other treumatic event, the Medical Examinating must be notified at Ance.		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of		Date			Town, State		
Baltimore,	ages int of t; If it		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		0	emetery, cren	natory or other pi Cremato		/28/2006					
	artme ortan injur		21. Signature of Funeral Service Lice				. Name and Add					•		
Ba	Depa Impo eny i		Ahuit	Stewart	711	_   -								
	23a. Part 1. Ender the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line.									Approximate				
	Pnysician		Immediate Cause (Final	one cause on each		MI			0 0 7					
	/Medical		disease or condition resulting in death)	aDue to (or as			E) WIT	M CON	11/11/74/1	ONS				
	Examiner			b										
	n #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):										
	ocute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last											
60,	te be executed ysician and te burial-transit													
	cate t	dical	•	d										
Box 68	ding	/Me	IF FEMALE:	23c. If yes, outcome	ol pregna	Incv								
Bo	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1□Live birth	2 Feta	Ideath 3□	Ectopic pregnan Other (specify)	су		23		•		
Division of Vital Records, P.O.	Attending Physician: The law requires that the death certificat reash.  r death.  sctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown		ou(ii	Cirio (Specify)							
۳.	that	by Pt	Part II. Other significant conditions	contributing to death I	out not resi	ulting in the u	nderlying cause g	given in Part I.	23e. Did	Reg. No.  Death Day, Year 12, 2006  4c. County of Death  4c. County of Death  4c. County of Death  4c. County of Death  9. Birthplace (State or Foreign Country) Wash., DC  10d. Inside City Limits 14 Yes 2 No  10g. Citizen of What Country? United States  No.  14. Race - American Indian, Black, White, etc. Specify: Black  16b. Kind of Business/Industry  Private  die, Maiden Sumame) eatrice Ball mber, City or Town, State, Zip Code) clboro, MD 20772  20c. Location - City or Town, State Clinton, MD  Funeral Home E. Wash., DC 20019  y arrest.  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death  23d. Date of delivery Month Day Year  24b. Were autopsy findings available prior the course of death? 1 Yes 2 No 3 Probably 4 Unknown  24b. Were autopsy findings available prior the course of death? 1 Yes 2 No 1 Yes 2 No				
g	auires n sig								1_	Yes 2	(No 3□Pr	robably 4 Unknown		
00	s been si s should I	ojet							24a. Was		24b. Were at	utopsy findings available		
æ	The la	Completed							perf	ormed?	death?			
ta	iclan: Th certificate rector, pag	BeC	25. Was case referred to medical					26. Place of	Death (Check only	_		2010		
<b>)</b>	Physic this ce al direc	ToE	examiner? 1 X Yes 2 ☐ No	Hospital: 1 X Inpati	ent 2	ER/Outpatien	t 3□ DOA	ther: 4 🗆 Nursi	ng Home 5□Res	idence 6	Other (Spe	cify)		
0	ng Pl		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inj (Month, Da		28b. Time of Injury	28c. Inj		e	how injury	occurred	16 0 m		
Sio	eath. or: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be	2/2//00		VNKNOW		□Yes 2 No						
$\leq$	or Attending I after death. Director: After in by the funer	Certification:	4 Homicide determined	28e. Place of In building, e	jury - At ho tc. <i>(Specif</i> )	ome, farm, str v)	et, lactory, office	ө	City or To	wn, State)	1040	WEIT		
	Hospital or 24 hours afte Funeral Dir tely filled in I		29a. Certifier 1 ☐ Certifying P	<del>`</del>		LUCTION		time data and a						
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely illied in by the funeral director, page 2	Medicai		miner: On the basis of and manner s	of examina	tion and/or in	estigation, in my	opinion, death	occurred at the time	date and p	place, and due	o to the cause(s)		
	To the within 2. To the complet	Me	29b. Signature and title of certifier	1 1	4.04.		29c. Lice	nse number		29d. Date	signed (Mont	h, Day, Year)		
}	r s r ö			1 /h-			00	CME		March	16. 2	006		
0	12		30. Name and address of person who	completed cause of	death (Item	1 23a) (Type.					, _			
-	0		MARY G. RIPP	L, mo				Penn Str	eet Balt	imore	, Mary	land 21201		
	Sta	_	31. Date liled (Month, Day, Year)	3 Regist	rar's Signa	ture								
4	Registr	ar	MAR 2 4 20	Ub Della	1	Apo								

			State of Maryland / D	Department of Health and Menta  Certificate of Death	•	006	11387
			Decedent's Name (First, Middle, Last)		te of Death		3. Time of Death
	Physici /Medic		Julian Homer Willey		onth arch 26	2006 ear	4:20 p M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Locetion of Death	40	. County of Death	
			2432 Andrews Road	Crapo		Dorches	ster
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	Months Days Hours Min. (M	te of Birth onth, Day, Year,	9. Birthp	olace (State or Foreign
	Director		218-16-6106 81	Yrs. Mar	ch 20,	1925 Mai	ryland
	land ow		10a. State 10b. County 10c. City, Town	or Location		1	I0d. Inside City Limits
	within 72 hours after death with the Maryland ene. then "neturel", or Items 23e or 28e-f show I.s Madical Examiner must be nailfied at	tor	MD Dorchester	Crapo			1 ☐ Yes 2 X No
Ź	r 28a	by Funeral Director	10e. Street and Number	10f. Zip Code	10g. Ci	tizen of What Cour	ntry?
3	h witi	aiD	2432 Andrews Road	21626		USA	
0	deat	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yolf Yes, specify Cuban, Mexican, Puerto Rican,	es or No-	14. Race - Americ	
9	or Ite	/Fu	1 ☐ Never Married 2 ☐ Marned 1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 No Specify:	oic.)	Black, White, Specify: whi	
8	urel',	d b	3 25-Wildowed 4 Divorced Year or Dates: WWII	•		***************************************	
21215-0036	"net	Completed	15. Decedent's Education 16a. (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. K	(ind of Business/In	dustry
7	withir ene. then	щ	Elementary/Secondary (0-12) College (1-4or 5+)	neavy equipment operator		construct	tion
დ დ	filled Hygi Sther		17. Father's Name (First, Middle, Last)	18. Mother's Name (First,			C1011
an	Id be ental ked c	To Be	Julian H. Willey	Mildred S	tewart	,	
Maryland	shound Mind Mind Mind Mind Mind Mind Mind Mi	-	19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and Number or Rural Route		or Town, State, Zip	Code)
	alth a 27 is		Andrew Willey son 2	2455 Andrews Road, Crapo	MD 2	1626	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or Items 23e or 28a-f show any injury or other traumatic event, It a Marical Examiner must be naillised at Once.		20a. Method of Disposition 20b. Place of	Disposition (Name of Date y, crematory or other place)		ocation - City or To	own, State
Ĕ	Page nent c		1 Es Dutial 2 Crestiation 3 Chamboat Itom 3/2/6	ew Market Cem. 3/29/06	Eas	t New Mar	rket. MD
alti	permit. Departn Imports any inju		21. Signature of Funeral Service Licensee			ral Home	
<u> </u>	8258		Bikibo	700 Locust St., Cambr	ridge, M	D 21613	
	Physician and /Medical Examiner the private in the	licai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the condition of the condi	of):			Onset and Death
P.O. Box 68	the death certifi by the attending ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
Records, F	w requires that been signed t should be det	by	Part II. Other significant conditions contributing to death but not resulting in Chronic obstructive pin monacy di	the underlying cause given in Part I. 23		use contribute to th	he cause of death?
000	aw requ is been 2 should	Completed	atheroscleratic cardiovascular Disp	24	4a. Was an		psy findings available
	ysicien: The lav is certificate has director, page 2.	mo	Tipe II Playetes mellitus	1	autopsy performed? ☐ Yes 2 No	death?	mpletion of cause of 2 No
Vita	icien: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?	26. Place of Death (Chec			
of <	Physic this ce al dire	O_	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	tpatient 3 DOA Other: 4 Nursing Home 5	Residence	6 □Other (Specif	y)
ion o	anding Phath. ar: After the funeral	ertification;	2 Accident investigation	ime of pjury M 28c. Injury at Work? 1 \( \text{Yes} \) Yes 2 \( \text{No} \) No	escribe how inju	ry occurred	
Division	tal or Att	Certific	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office 28f. Lo	cation (Street arity or Town, State	nd Number or Rura e)	al Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination and and manner stated.	, death occurred at the time, date and place, and dud/or investigation, in my opinion, death occurred at the	e to the cause(s he time, date an	) and manner as si d place, and due to	tated. the cause(s)
	To t. To tl	ž	29b. Signature and title of certifier	29c. License number		te signed (Month,	
			I all Lelly mo	DS0804	7	3-27-1	06
			30. Name and address of person who completed cause of death (Item 23a) (	Type, Print)		0	21613
	Sta Registr	_	31. Date filed (Month, Day, Year)	you street Cambrid	7	7	1 T. 1 E

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Waters 10:30p.M Ma March 25 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crisfield Somerset Byrd Wursing Home 7. Age (In yrs. last birthday) Tawes If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 M 2 F 089-22-7263 Director ivginia Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28e-f show other treumatic event, the Medical Examinar must be notified at 1, Yes 2 No Director Maryland Somerse 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21817 U.S.A Hall Items 23e 201 Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 1 No If Yes, Give / Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 ö 1 ☐ Yes 2 ☑ No Specify Specify: Black 3 Widowed 4 □ Divorced "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (Q-12) College (1-4or 5+) Private tami Home 10-th grade | 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) nt of Health a t: If Item 27 le y or other tree 80 92 Gills June Waters Rhodes-Sister-in-Law Upper Lane ma 3altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page Department or Importent: If I any injury or once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 3/29/06 MG 4 □ Donation 5 □ Other (Specify) Md. Veteraus Cemeter 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Authory 30639 Hampden md 2185 Ave 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASC V P /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, by Physician/Medical as the IF FEMALE. 9SD 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) the of Vital Records, P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes No or Attending Physician: Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes No Other: W Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

MAR 2 8 2006

Vijay Karumbunathan,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, M.D. - 201 Hall Highway - Crisfield, MD
32. Registars Signature

D 48098

2006

21817

NLM 06-01886 Arneaud Wilford

riease	Type or Print	in plack indeli	Die ink. Ens	ure All Copies	s Are Legii
	State of Man	yland / Departm	ent of Health	and Mental Hy	giene -

au	IG WIII	)L(	For State Registrar	State of Mai		artment of ertificate of		wentai ny	Reg. No.	106	1389
			Decedent's Name (First, Middle, Las					2. Date of D	eath		3. Time of Death
	Physici /Medio		ARNEAUD	Edward	d WIL	ford 1	111	Month Marc	h 16.	2006	11:44 PM
	Examir	er	4a. Facility Name (If not institution, give				or Location of Dea	th	4c. 0	County of Death	
	Funeral		501 Heather Ridge 5. Social Security Number 6. Se		pt A (In yrs. last birthday		Frederick	8. Date of B	rth		
	Director		212-86-4461 1	M 2□F	41 Yrs.	Months Days	Hours Min	June June	av Voari	64 NE	place (State or Foreign intry) WYORK
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits
	Mary!	į	MD Frederi	1	Frederi						1 Ø Yes 2 □ No
	th the	irec	10e. Street and Number 501 Heather	2.7		10f. Zip Code	_		10g. Citiz	en of What Cou	intry?
	ath wi	raf	501 Heather				1702			S. A.	
	tter de	by Funeral Director	11. Marital Status  Never Married 2 Married	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or N to Rican, etc.)		<ol> <li>Race - Ameri Black, White</li> </ol>	, etc.
99	ref, or	by	3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1□Yes 2☑No	Specify:			Specify: $Bl$	ack
	within 72 hours after death with the Maryland ene. then "neturel", or teme 23a or 28a-f ehow ta Mudical Exercitar must be publiked at	Completed	15. Decedent's Ed (Specify only highest grad		(Give	edent's Usual Occu a kind of work done DO NOT use retin	e during most of wo	orking	_	d of Business/li	ndustry
21215-0036	iene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+	1	tance			/	deric	k
힏	be filed ital Hygid of other event, I	ge C	17. Father's Name (First, Middle, Last)	1/15	17			me (First, Middle	a, Maiden S	Sumame)	
yla	ould by	To Be	Arneaud John	Wilter				E. Ro			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryiar if Health and Mental Hygiene if Health and Mental Hygiene flem 27 is marked other then "neture!", or theme 23a or 28a-f show then traumatic event, the Medical Exactions trunk to notified at		19a. Informant's Name/Relationship (TRASTOR ROGER R.				at and Number or R				
re,	of Health		20a. Method of Disposition		20b. Place of Disp	osition (Name of		Date	20c. Loc	ation - City or T	own State
Ë	Pages ment of ant: If It ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State )	Sunnysi	de um C	Cem. MAN	L 28, 201	×54	nay sid	te Md.
Baltimore,	permit. Page Depertment o Important: If any Injury or once.		21. Signature of Funeral Service Licens	0000	Sunny Si	2. Name and Add	ess of Facility /	TNORAL	Hom	E M	d 21701
			23a. Part1, Enter the disease, or comp	lications that caused t	ne death. Do not en	to was 1 ter the mode of dy	ring, such as cardia	c or respiratory	arrest, A	n m	Approximate
	Physician		shock, or head failure. List only of Immediate Cause (Final disease or condition		gun W	muel -	to the	Hea	d		Interval Between Onset and Death
	/Medical Examiner		resulting in death)		consequence of):	Order	10 100	., .	~		
	LAdminer	J.	Sequentially list conditions, if any, leading to immediate	b	consequence of):						
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	с.	55.102 420.102 51/.						
0,	e exec ien an urial-tr		resulting in death) Last		consequence of):						
68760,	rificate be executed ng physicien and as the burial-transit	edicai	•	d							
		-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23	3d. Date of deliv	verv
W	death	Physician/N	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown		□Ectopic pregnan □ Other (specify)	cy			Month	Day Year
P.O. Box	The law requires that the death cer ete hes been signed by the attendir page 2 should be detached for use	Phy	9 Unknown		ant consisting in the		in Continue	220 Did	taba asa wa		Abo course of death?
	signe d be c	d by	Part II. Other significant conditions co	intributing to death but	not resulting in the t	underlying cause g	IVen in Parti.	_		,	the cause of death?
CO	w require s been si should I	iete						24a. Wa		•	opsy findings available
Division of Vital Records,	Physiclan: The lav this certificete hes ral director, page 2	Completed						_ perf	opsy omed? 2 \( \text{No} \)	prior to co death?	ompletion of cause of
/ita	Attending Physiclan: r death. ector: After this certificaby the funeral director,	Be	25. Was case referred to medical examiner?			4		ath (Check only			
<b>d</b>	Physi this c	-T	1 AYes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 28a. Date of Injury	t 2 ER/Outpatie	AIL SELDON		Home 5 Res			ify)
on	nding F th. :: After e funer	ation	1 □Natural 5 □ Pending 2 □ Accident investigation	(Month, Day	Year) Injury	~ W	ork? □Yes 2 No	Decel	_//	shot	2
<u>×</u>	r Atternet designation	Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur building, etc.	y - At home, farm, st		•	_		Number or Ru	rai Route Number
Ω	Hospital or 24 hours efte Funeral Dir tely filled in		200 Continue 451 Continue 20		home	4		HOAA.7	main	CK, MD	21702 Fred Co
	To the Hospital or Attending within 24 hours effer death.  To the Funeral Director: After completely filled in by the funer	edicai	29a. Certifier 1 Certifying Phy (Check only 2 Medical Examone)	vsician: To the best of iner: On the basis of e and manner state	my knowledge, dea examination and/or it ad.	in occurred at the nvestigation, in my	time, date and place opinion, death occ	e, and due to the surred at the time	cause(s) a , date and p	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier		4.	29c. Licer	nse number		29d. Date	signed (Month	, Day, Year)
			2 IVA	VX/	4		O.C.M.	Ε.	Ma	rch 17,	2006
			30. Name and address of person who o	omcleted cause of ve			treet Bal	timore			
	Sta	ite	31. Date filed (Month, Day, Year) 20	GE 32 Registrar							
3.	Registi	ar	MIAK ~ 1 ZU	06 January	's Signature	new					
DH	MH 17 Rev 1/2	001									

	•	1- State of Ma	ryland				lealth an D <i>eath</i>	d Me		jienė   •g. No.		11390
		Decedent's Name (First, Middle, Last)						2	. Date of Dea	th	V	3. Time of Death
Physicia /Medica		John Roy Young							Month 34	Day	2006	9:02 N
Examine		4a. Facility Name (If not institution, give street and number)			4b. City,	Town, or	Location of D	eath		4c. Co	unty of Death	
		Atlantic General Hospital				Berl					orcest	
uneral		5. Social Security Number 6. Sex 1 1 2 M 2 1 F	(In yrs. las	t birthday) Yrs.	Months	Days	If Under 24 Hours	/lin.	. Date of Birth (Month, Day	, Year)		place (State or Foreign htry)
ctor		Usuel Residence of Decedent	- 03	110.				A	ug. 5,	1942_	Wasii	ington, DC
cociffied at		10a. State 10b. County	10c. City, 7	Town or Lo	cation						1	Od. Inside City Limits
	ctor	Maryland Anne Arundel		Edgev	water							1 ☐ Yes 2 💆 🖎
	Dire	10e. Street and Number			10f. Zij	Code	4005		1	•	of What Cour	ntry?
	rai	606 Londontown Road	una in II C	12.1	Nac Dass		1037	2 (Coope	fu Van ar Na		USA Race - Americ	an Indian
	Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married 12. Was Decedent E Armed Forces?  1 □ Yes 2 ☑ Married					ispanic Origin' n, Mexican, P	uerto Ri	can, etc.)	14.	Black, White,	
	۾	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		1	1 🗌 Yes	2 <b>X</b> No	Specify:			Sp	ecity: Whi	te
	Completed	15. Decedent's Education (Specify only highest grade completed)		16a. Deced	dent's Usu	al Occupa	ation during most of	working		16b. Kind	of Business/In	dustry
1	mpie	Elementary/Secondary (0-12) College (1-4or 5-	+)					3		D-1-		
		10 17. Father's Name (First, Middle, Last)		Route	e Sai	esina		Name (	First, Middle, I	Bak Maiden Sui		· -
- 1	o Be	John Richard Young, III					Thelma					
ď	၉	19a. Informant's Name/Relationship (Type, Print)		19b. Mailin	ng Addres	s (Street a	and Number o	r Rural F	Route Number	, City or To	own, State, Zip	Code)
		Patricia A. Young/Wife	6	506 L	ondon	town	Road	Edg	ewater	, Mar	yland 2	21037
		20a. Method of Disposition	20b. Plac	e of Dispo	sition (Na	me of other plac	e)	Dat	е	20c. Locat	ion - City or To	own, State
		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	Kala	as Cre	emato	ry	4	4-06		Edgew	ater, 1	Maryland
- Duce		21. Signature of Edward Service Licensee										al Home
		100000									ter, M	D. 21037
		Onset and Dea										Approximate Interval Between Onset and Death
an		Immediate Cause (Final disease or condition resulting in death)			CAR	DIA	6 141	FAR	CTION	,	//	MAEDIATO
cal ner		Due to (or as a	consequer	nce of):							_	
	e	Sequentially list conditions, if any, leading to immediate b. Due to (or as a	consequer	nce of):							NE.	WYEARS
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events										
1	Exa	resulting in death) Last Due to (or as a	consequer	nce of):								
	dical	d										
	/Mec	IF FEMALE. 23c. If yes, outcome of	of pregnance	v							Date = 4 1 11	
	by Physician/Me	in the past 12 months?	2 Fetal de	eath 3	Ectopic p					23d	. Date of delive Month	ery Day Year
	ysic	1 Yes 2 No 9 Unknown 9 Unknown	0. 0041		(3)							
i	y P	Part II. Other significant conditions contributing to death but	t not resulti	ng in the ur	nderlying (	cause give	en in Part I.		23e. Did tol	pacco use	contribute to the	ne cause of death?
	ed to								1 □ Ye	s 2 N	lo 3 Prob	pably 4 Unknown
	piet								24a. Was an autopsy finding prior to completion of			psy findings available
	Completed								perforr	ned?	death? 1 ☐ Yes	
-13	Be	25. Was case referred to medical examiner?						Death (	Check only on	θ)		
	ို	1 Yes 2 No Hospital: 1 ☐ Inpatie		VOutpatien			4 🗆 Nursir				Other (Specif	y)
	on	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injur (Month, Day)	Year)	Bb. Time of Injury	M	28c. Injury Work	rat c? Yes 2 □ No	28	d. Describe ho	w injury of	ccurred	
	Certification:	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Inju	rv - At home	e. farm. str				28	. Location (St	reet and N	umber or Rura	il Route Number,
	erti	4 Homicide determined building, etc	(Specify)	-,,		y, <b>u</b> u			City or Town	, State)		
	a C	29a. Certifier 1 ☐ Certifying Physician: To the best of										
:	edical	(Check only one)  2 Medical Examiner: On the basis of and manner sta		n and/or inv	vestigation	ı, in my op	pinion, death o	ccurred	at the time, d	ate and pla	ice, and due to	the cause(s)
1	ž	29b. Signature and title of certifier		1	29	c. License			2		gned (Month,	
		Dorothy C. Hogworth,	Mi	S.		1	0624	1		04-	02-04	6
1		30. Name and address of person who completed cause of de							473		,	
		JOKOTHY C. HOLZINGORTA 31. Date filed (Month, Day, Year) 38. Registra	r's Signature	1.2.	-	163	SNOW	57,	SNO	W H	ice, M	0,21863
Stat gistra	7	31. Date filed (Month, Day, Year)  33. Registra	K	Local	120							

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

APR 1 0 2006

32. Registrar's Signature

			1 - For State Registrar	State of Mar	yland / Dep		f Health and	Re	ene g.No.006	11392		
	Physici /Medi Examir	cal	Decedent's Name (First, Middle, La     Johanna     4a. Facility Name (If not institution, giv		2. Date of Death Month March	Day Year 19 2006	3. Time of Death 4:00 a M					
	Funeral Director		Hospice House 5. Social Security Number 6. S	ex 7. Age (	In yrs. last birthday) 80 Yrs.	Linth If Under 1 Ye Months Da	ar If Under 24 H		Anne Ar Year) 9. Bin Co 1926 Ger	unde1  thplace (State or Foreign ountry) many		
Nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If then 27 is marked other than "neturel; or thems 23a or 28a-1 show or other traumatic event. The Medical Examiner must be notified at	tor	Usual Residence of Decedent  10a. State 10b. County  MD Anne A	runde1				10d. Inside City Limits 1 ☐ Yes 2 ☐ No					
	72 hours after death with the neturel', or Items 23a or 28s iteal Examiner must be not	eted by Funeral Director	10e. Street and Number  1005 Annapolis  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's E (Specify only highest gr.	12. Was Decedent Event Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates:	16a, Dece	Was Decedent of If Yes, specify C	1054 of Hispanic Origin? cuban, Mexican, Pur	(Specify Yes or No- orto Rican, etc.)	10g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: White  16b. Kind of Business/Industry			
	2 should be filed within and Mental Hygiene. is marked other than " aumatic event, Its Men	To Be Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last Gustav Wepil	College (1-4or 5+)	Hom			Own Home  e (First, Middle, Maiden Surname)				
e, Maryland	1 and 2 shou Health and M Iom 27 is mar other traumat		19a. Informant's Name/Relationship ( Thaddeus Zarudz 20a. Method of Disposition	ki (Husband	) 1005	Annapo	lis Road,	Gambrills	City or Town, State, A	4		
Baltimore,	permit. Pages Department of H Important: If Ite any injury or of		1 Burial 2 Cremation 3 4 Donation 5 Other (Special 21. Signature of Funeral Service Life)	y)	20b. Place of Dispresentery, cre Metro Cr	ematory	3-2		Baltimore,			
	Fuysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mod of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.  Approximate Interval Betwoest and D									
68760,	death certificate be executed  a attending physician and a for use as the burial-transit	ical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a co	consequence of):	Conc	e di	sea Se	2			
, P.O. Box 68 that the death certificate ed by the attending phy detached for use as the		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Vo	23c. If yes, outcome of 1 ☐ Live birth 2   4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	⊒Ectopic pregna ⊒ Other (specify			23d. Date of de Month	livery Day Year		
Records, P.	The law requires that the ate has been signed by the page 2 should be detache	by	Part II. Other significant conditions	contributing to death but r	not resulting in the t	underlying cause	given in Part I.		acco use contribute to	Δ_		
tal Reco	ician: The law r certificate has be rector, page 2 sh	e Completed	25. Was case referred to medical				DC Pleas of D		prior to death?	utopsy findings available completion of cause of		
on of aling Phys	Certification: To Be	examiner?  1 Yes EX No  27. Manner of eath  1 Natural 5 Pending investigation investigation			of 28c. I	Othor	eath (Check only one Home 5 Resider 28d Describe ho	nce 6 Other Spa w injury occurred	dispertus			
Division	pital or Att ours after d erel Direct		3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office City or Town, State)  29a. Certifier  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner									
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical	(Check only one)  2 Medical Example (Check only one)	miner: On the basis of example and manner states	camination and/or in	ivestigation, in n	ense number	curred at the time, da	te and place, and due	e to the cause(s)		
•		_	30. Name and address of person who	pompleted cause of deal	th (Item 23a) (Type.	Print) A	25 GO:	) ( > )	3/23	to IND		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	6 Pagistrar's	Signature	<u> </u>	11040		11 TUNI	'Zilliz'		

			For State Registrar	State of Ma	aryland		rtment of H		nd Mental Hy	giene Reg. No.	nns.	11000	1
			Decedent's Name (First, Middle,	Last)					2. Date of De	eath	<del>Vana</del>	3. Time of Death	<del>)</del>
	Physici		Charles Emory E	rown, Jr.					Month	Day	2000	0 9 10AN	1
	/Medic Examir		4a. Facility Name (If not institution,				4b. City, Town, o	r Location of	Death	4c. C	County of Death	1	
	-Admin		BelaRHANH	and Ret	dia		Pro 1	liB		1	HOGE.	cd	
	Funeral				e (In yrs. la	st birthday)	If Under 1 Year	If Under 2	Min. 8. Date of Bi	rth	9. Birth	nplace (State or Foreig	n
	Director		219-16-9190	1 <b>3</b> M 2□F	81	Yrs.	Months Days	Hours		1/192			
	<b>D</b>		Usual Residence of Decedent									10.1.1.1.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2.2	
	rylar how		10a. State 10b. County	,	10c. City,	Town or Lo	cation					10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	n the Marylan r 28a-f show	cto	MD Harfo	rd	Abi	ngdon							
	if th	Oire	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	untry?	
	after death with or items 23e or	Funeral Director	200 White Oak C	ourt, Apt. 1	В		21009				ted Sta		
	em a	ne	11. Marital Status	12. Was Decedent E Armed Forces?		i. 13. V	Was Decedent of H f Yes, specify Cuba	lispanic Orig an, Mexican	jin? (Specify Yes or N , Puerto Rican, etc.)	0- 1	<ol> <li>Race - Amer Black, White</li> </ol>		
99	or in	by Fu	1 Never Married 2 Marrie	If Yes, Give			I□Yes 2⊠No	Specify:			Specify: Whi		
Ö	72 hours "naturel",	g p	3 SWidowed 4 □ Divorced	Year or Dates:	1943-	-				10h Kin	id of Business/l		
<u>2</u>	"natu	Completed	15. Decedent's (Specify only highest	grade completed)		(Give	lent's Usual Occup kind of work done DO NOT use retired	ation during most	of working	Ste		industry	
12	then then	Ę.	Elementary/Secondary (0-12)	College (1-4or 5	i+) 2	Mach		3)		200			
2	filed within 72 hours after death with the Maryland Hygiane. Hygiane then "naturel; or items 23s or 28s-f show ent, the Medical Examiner must be mollified.		17. Father's Name (First, Middle, L		2	1101011.		18. Mothe	r's Name (First, Middle	a. Maiden S	Sumame)		
ano	ntal o d o	Be	Charles Emory B	-					oria Koeni		,		
Maryland 21215-0036	should be nd Mental marked c	은	19a. Informant's Name/Relationshi		-	19b Mailin	a Address (Street	and Numbe	r or Rural Route Numb	per. City or	Town, State, 2	(in Code)	
_ B	d 2 s th an 17 ts trau	1	Mrs. Judith Evar						t, Apt. B				
نه	8 9 E 2		20a. Method of Disposition		20b. Pla	ace of Dispo	sition (Name of	1	Date		cation - City or		
Baltimore.	Pages nent of ont: If its		1 ☐ Burial 2 🗷 Cremation		1		natory or other place. ke Crema		Apr 12		csville.	Maryland	
量	ritme riteni		4 □Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		Cne		. Name and Addre			Der	.oviiic,	.mrj.m.	
Ba	permit. Pages 1 Department of h importent: if ite eny injury or ot since.		Sura Lu	e Putter M	0144	\ \ C	Cremation	and Fu	ineral Alter			aryland 2128	36-
			23a. Part1. Enter the disease, or o shock, or heart failure. List o	omplications that caused	the death.	Do not ent	er the mode of dyir	ng, such as	cardiac or respiratory	arrest,		Approximate Interval Between	
	Pnysician		Immediate Cause (Final disease or condition	X =1	. )		Do	- L	5 -			Onset and Death	
	/Medical Examiner		resulting in death)	a. Due lo (i) a	a conseque	ence of):	Mari	Chi	Les			years	
			Our and the link are distant									/	
7		je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	anca or).							
V	outad od ransi	Examiner	that initiated events	с.									
o.	an ar		resulting in death) Last	Due to (or as	a conseque	ence of):							
8760,	cate be executed physician and the burial-transit	dlcal	•	d									
9		Ved	15.55141.5		-	7/32							-
Вох	daath cartifi a attending od for use as	Ş	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			Ectopic pregnanc	v		2	3d. Date of del		
	D 00 D	100	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregnant at 9☐Unknown			Other (specify)				Month	Day Year	
() Q	at the da by tha tached	Physician/Me	9 🗆 Unknown	9LI OTIKTOWN		A a r							-
		Ď.	Part II. Other significant condition	s contributing to death be	ut not resul	Iting in the u	nderlying cause giv	ven in Part I.	<			the cause of death?	
> p	w require been sig should b	P P	Chronic O	b struct,	ve_	Y4 11	monari	1 4	sease 10	Yes 2	∄No 3□Pr	obably 4 Unknow	'n
N, Charli	aw requis been 2 should	Completed by	Cl same	2001 7	h. a	. CP	0 /		24a. Wa	s an opsy	24b. Were au	topsy findings availab completion of cause of	le
3	Tha lavate has	E	Chronic x	sena J	nc.	WHI	cience	)	per 1 □ Yes	formed?	death?	Z No	
Ta E		BeC	25. Was case referred to medical					26. Place	of Death (Check only	-			_
	Physician: r this certific ral director,	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2□E	R/Outpatien	t 3 DOA Ott		rsing Home 5 Res	-00-	☐Other (Spe	cify)	
Ž b	ar thi		27. Mann Death	28a. Date of Injur		28b. Time of		ry at	28d. Describe	how injury	occurred .		
Brough	Attending F r death. ector: Aftar by the funer	atlo	Natural 5 Pending 2 Accident investiga		y 1 6a1)	Injury		Yes 2 ☐ i	No				
	Atte	2	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	289. Place of Inju	ury - At hon	ne, farm, str	eet, factory, office			(Street and		ural Route Number,	
百分首	al or Direction	Certification:	4   Homicide	building, etc	c. (Specify)	,			City of 1	Jwn, State)			
	To the Hospital or Attendi within 24 hours after death. To the Euneral birector: A completely filled in by the fu		(Check only 2 Medical E	Physician: To the best of xaminer: On the basis of	f examination	vledge, death on and/or in	n occurred at the tr vestigation, in my o	me, date an opinion, dea	d place, and due to the	e cause(s) e, date and	and manner as place, and due	s stated. to the cause(s)	
	o the	Medical	one) 29b. Signature and title of certifier	and manner sta	3160		29c. Licens	se number		29d. Date	e signed (Mont	h, Day, Year)	_
	- 11		) / Man	WM I	/	116	1	1101	72	An	KI.	1 200	/
	/X		30. Name and address of person w	the completed cause of d	eath (Item	23a) (Type,	Print)	×1.03	47	11	<del>\\ \\ \\</del>	1,000	6
	2)		Mamel Y	1. 67	5~	MD	, 1	Lan	N Street	IXX	ppvds	een,	
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registra	ar's Signati	ure			rian	7 141	29 2	-1001	
	Regist		APR 1 2	2006	de	· An	all I						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 9 2006 April 11:00 AM Ohn BristoW 4c. County of Death 4b. City, Town, or Location of Death Name (If not institution, give street and number) Kline Hospice House Mt. Airy Carroll 8. Date of Birth (Month, Day, Year)
Dec. 12, 1929 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Min 1 ☑ M 2 ☐ F 173 - 22 - 979 Usual Residence of Decedent 76 Yrs. Maine 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ☑ No Florida Bradenton Manatee 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3713 16th Street West 34205 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Manager Food Industry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John M. Bristow Prudence Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Grandson) 3909 Shawfield Lane Urbana, Maryland 21704 Justin Bristow 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State Manasota Memorial Pk 4-14-2006 4 Donation 5 Other (Specify) Bradenton, FL 22. Name and Address of Facility Witzke Funeral Homes, Inc. 5555 Twin Knolls Road Columbia, Maryland 21045 21. Signature of Funeral Service Licensee MY Ja 23a. Part1. Enter the dipease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) WERK Cancer Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate the second of as a consequence of) resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery decedent pregnant 3 Ectopic pregnancy past 12 months? Month 4☐Pregnant at time of death Yes 2 No Jnknown 5 Other (specify) 9 Unknown er significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? iere byo Vascular 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes 1 TYes ase referred to medical 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred r of Death 28b. Time of 28c. Injury at Work? H8454 Injury itural 5 Pending

Examiner Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 Be Completed by Physiclan/Medical Certification: To After thi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital

Physician

/Medical

Examiner

**Funeral** 

Director

or 28a-f show

Itama 23a

other treumstic event, the Medical Examiner must be notified at

ō permit. Page Department of Important: If eny injury or once.

**Physician** 

/Medical

Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene. ant: If item 27 ie marked other than "natural", or Itama 23

Baltimore, Maryland 21215-0036

**Funeral Director** 

Be Completed by

with the Maryland

IF I	o. V ir 1		3
Par	t II.	01	h
25.	θХ	as am	ir
27.	Ma 1	inn	e

29a. Certifier

(Check only one)

29b. Signature and title of certifier

Medical

State

Registrar

М investigation 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

Shah 787. M17

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas honron

31. Date filed (Month, Day, Year)

32. Registrar's Signature APR 1 2 2006

÷

		1 - For State Registrer	State o	of Marylar		artment of I rtificate of		nd Mental Hy	giene Reg. No. U 0 6	1395		
100000	sician edical	al								3. Time of Death 1530 PM		
Exar	miner	SAINT AGNES HOSPITAL BALTIMORE							4c. County of Death N/A			
Funer Direct		5. Social Security Number 231 – 36 – 3518	6. Sex 1 ☐ M 2 <b>X</b> F	7. Age (In yrs. 74	last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birt Min. (Month Da April	<sup>h</sup> <sup>y</sup> 26,1931	place (State or Foreign intry) VA		
Maryland f show	or	Usual Residence of Decedent  10a. State 10b. County  MD	N/A	10c. Ci	ty, Town or Lo	cation timore				10d. Inside City Limits 1 🗗 Yes 2 🗆 No		
Maryland 21215-0036 td 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Mudical Examinations the mullind at	Director	10e. Street and Number	d Pky			10f. Zip Code	21229		10g. Citizen of What Cou US	•		
	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Fo	2 XNo		Was Decedent of If Yes, specify Cub		? (Specify Yes or No Puerto Rican, etc.)	14. Race - Amer Black, White Specify: B1	, etc.		
	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade completed)			dent's Usual Occu kind of work done DO NOT use retire SeWife	pation during most o	f working	16b. Kind of Business/Industry  Own Home			
	To Be Co	12th 17. Father's Name (First, Middle, I Ernest Hard			noue	,0,110		Name (First, Middle,				
> == ~ =		19a. Informant's Name/Relationsh Phyllis Robin				-			or, City or Town, State, Z.			
Baltimore, I permit. Pages 1 and Department of Healt important: If item 2 any injury or other		20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sp		State Ar	Place of Dispo cemetery, crem OUTUS	sition (Name of natory or other pla Memoria	al Pk	Date 4/15/06	20c. Location - City or 1 Arbutus			
Balt permit Departm imports	SUCE	21. Signature of Juneral Survice	eris			Name and Address			Harris Fu Baltimore			
SY 60, cate be executed hysician and chysician and the burial-transit	dical Examiner	23a. Part. Enter the disease, or enock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	each line.	nceph quence of): quence of):	er the mode of dy		rdiac or respiratory ar	rest,	Approximate Interval Between Onset and Death 272 incurs 72 incurs		
I HECOTGS, P.O. BOX 68/60,  The law requires that the death certificate be executed attends been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live t	tcome of pregna birth 2 Feta nant at time of co	ıldeath 3 [	Ectopic pregnanc Other (specify)	y		23d. Date of delive Month	very Day Year		
quires that quires that on signed b		Part II. Other significant conditio	ns contributing to d	eath but not res	sulting in the u	nderlying cause gr	ven in Part I.		obacco use contribute to	/		
		25. Was case referred to medical		•				1 ☐ Yes	prior to c death? 2 No 1 Yes	opsy findings available ompletion of cause of		
	o Be	examiner?	Hospital:	Inpatient 2	ER/Outpatien	t 3 DOA Ot		Death Check only o		(fv)		
DIVISION Of VITA  for Attending Physician; after death.  Director: After this certification by the funeral director,	ation: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investig	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury	28c. Inju		28d. Describe h	5 Residence 6 Other (Specify)  Describe how injury occurred			
DIVIS tal or Atta s after de al Directo ed in by th	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)										
DIVI:  To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edicai	one)	:xaminer: On the b	e best of my kno asis of examina ner stated.	owledge, death ation and/or inv	estigation, in my	opinion, death	place, and due to the occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)		
To t To t	Σ	29b. Signature and title of certifier  Muluk	musesfallio	(medi	od Rosid	29c. Licen.	8612		29d. Date signed (Month April, 09)	. Day, Year) 2006		
7		30. Name and address of person of MUHAIMMA	D TALHA	se of death (Iter	т 23а) (Туре,	Print) 900	S. Ca	ton Aven	April 09, we , Baltm	ione, MD		
100 B G C 100 B C 100	State istrar	31. Date filed (Month, Day, Year)  APR 1 2	2006	registrar's Signa	ature	we we						

DHMH 17 Rev 1/2001

Amend items 4a-c per doc, amend items 10a.b.c.e.f per fh 884 4-20-06 vt.
Please Type or Print in Black indelible ink. Ensure All Copies Are Legible.
Amend item 23b per doc 8854 4-12-06 vt.
State of Maryland? Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No: 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Gerald McNev Bowman 5:15 April 3, 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution give street and number) 4c. County of Death Examiner Charlotte Charlotte Hall St. Mary's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1ДM 2□ F 83 Yrs. 577 24 6295 Director June 5. 1922 Washington. Usual Residence of Decedent 10b. Count St. Mary's with the Maryland 10a. State Charlotte Hall 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show other traumatic event, the Madical Examiner must be notified at 1 Yes 2 No Maryland Prince Oxon Hill Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 29449 Charlotte Hall Road 20622 702 Shelby -20745United States filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? tr∃Yes 2□No KYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married XX Married Korean Baltimore, Maryland 21215-0036 1 ☐ Yes 2☐ No Specify: White Specify þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ai Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Editor Washington Gas Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental Hight: if item 27 is marked other Be David B. Bowman Lillian McNev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine L. Bowman (Daughter) 6510 Old Carriage Drive, Alexandria, Va 22315 20b. Place of Disposition (Name of cemetery, crematory or other place) April 6, Da . 2006 20c. Location - City or Town, State 20a. Method of Disposition ŏ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 22. Name and Address of Facility Lee Funeral Home, Inc, 663301d 21. Signature Euneral Service Alexandria Ferry Road, Clinton, MD 20735 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cardio respiratory **Physician** /Medical Due to (or as a consequence of): Examiner Asplyation pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) The law requires that the death certificate be executed Dementia resulting in death) Last Due to (or as a consequence of) Medical Certification; To Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ You 3 Ectopic pregnancy 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2000 No 2 No 1 Yes 1 Tyes of Vital To the Hospitel or Attending Physicien: completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural
2 Accident Division 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 47066 Asshah 4.3.06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leonardtown, MD 20650 Avani D. Shah. 22650 Cedar Lane Court, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2006

State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>Day</sup> 2006 **Physician** Month Ruby R. Barbour April 9, 10:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Pay, 9. Birthplace (State or Foreign **Funeral** 1 M 2 X 578 20 6670 92 North Carolina Yrs. Aug /, Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Items 23a or 28a-1 ehow eny injury or other traumatic event, the Medical Exemina. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√X No Maryland Prince George's Clinton Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11010 Welch Street 20735 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 20 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 1 1 10 Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 7th Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Julius Johnson Mary Jane Eli Strickland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruby Sandra Rogers (Daughter) 14410 Scalloway Place, Charlotte Hall, MD 20622 20b. Place of Disposition (Name of cemetery, crematory or other place) April 13, 2006 20c. Location - City or Town, State 20a. Mathod of Disposition 1 A Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Maryland 21. Signatury of Fundral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d Alexandria Ferry Road, Clinton, MD mo1461 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) paraction yo Carded Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit ettending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical use as the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death signed by the eld be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown peeu 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 24 No certificate 1 ☐ Yes Attending Physician: within 24 hours atter death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only one Hospital: 1 fnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 (Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25640 April 11, 2006 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Khosrow Davachi, M.D. 7801 Old Branch Ave, #409, Clinton, Maryland 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2 2006

State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** APRIL 8,2006 MICHAEL 2:40 a M BARNYCZ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KESWICK MULTI-CARE CENTER BALTIMORE N/A | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | SEPT. 3, 1932 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1XM 2□F 212-32-0349 Director UKRAINE Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d, Inside City Limits or items 23a or 28e-f show 1 XYes 2 No Director MD. N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 700 W. 40th STREET U.S.A. 21211 by Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

M☐Yes 2☐No 11Yes, Give Year or Dates 1952-54 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Injury or other traumatic event, the Medical Execution Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If Item 27 is marked other than "naturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced WHITE Completed 15 Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 SUPERVISOR MANUFACTURING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ JOHN BARNYCZ ANNA MACHYSHYN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) STEPHANIE POLISCHUK/SISTER 9209 GARDENIA ROAD, BALTIMORE, MD. 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any Injury or once. MICHAEL'S UKRAINIAN 4/11/06 BALTIMORE, MD. 4 ☐Donation 5 ☐ Other (Specify) LILLY & COUNTY OF THE COUNTY O 21. Signature of Funeral Source Licensee 1901 EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease Physician artin menoso disease or condition resulting in death) /Medical Due to (or as a co nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Physiclan/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Pagt II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mun CANUR 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performes osstrictive Morne 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Marin of Death 1 atural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? or Attending Fafter death. After 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide To the Hospitel within 24 hours a To the Funerel C 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Ballimore Ma 21204 ed cause of death (Item 23a) (Type, Print) 30. Name and address of person 670 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006 APR

			1 _ State	partment of Health and ertificate of Death		DITTE	11399
			Registrar  1. Decedent's Name (First, Middle, Last)	erinicale of Dealif	2. Date of Dea	th	3. Time of Death
П	Physici	an			Month	Day Year	
-	/Medio Examir		Thomas Earl Borneman  4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	17	30 2006 4c. County of Death	12:30pm <sup>M</sup>
	LAdilli	CI	Harford Memorial Hospital	Havre de Grace		Harkord	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		8. Date of Birth (Month, Day	4	pface (State or Foreign intry)
ı.	Director		215-30-2840 1X M 2□F 84 Yrs.	Wildright Days Flours Willing	11/02/1	921 Mari	yland
	and *		Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location			10d. Inside City Limits
	Manyli f •ho	ō		de Grace			1 ☐ Yes 🎾 No
	28a-	rect	10e. Street and Number	10f. Zip Code	1	log. Citizen of What Cou	untry?
	3a or	0	1013 Morrison Blvd.	21078		USA	•
	death	by Funeral Director		Was Decedent of Hispanic Origin? (S     If Yes, specify Cuban, Mexican, Puer	pecify Yes or No-	14. Race - Amer	
ထ္ထ	or its	/Fu	1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No	1 ☐ Yes 2 ☐ No Specify:	to moan, atc.,	Specify: (11/a	
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or iteme 23s or 28s-f ehow ha Madical Examiner must be notitled at	q p	3 Wildowed 4 Divorced Year or Dates: 1945-46			WIL	
7	n 72	Completed	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ve kind of work done during most of wo b. DO NOT use retired)	rking	16b. Kind of Business/I	ndustry
12	withi ene. than	дшс	Elementary/Secondary (0-12)   Colfege (1-4or 5+)	lh-Employed		Rental Com	ากสทุน
2	Hyg other	Be C	17. Father's Name (First, Middle, Last)		ne (First, Middle, i		p 00,09
<u>a</u>	uid be Aenta rked tic ev	To B	Thomas Borneman	Helen	Townsley		
Maryland	and N		19a. Informant's Name/Relationship (Type, Print) 19b. Ma	tiling Address (Street and Number or Ri	ural Route Number	r, City or Town, State, Zi	ip Code)
Σ,	and and and and and and and and and and			Morrison Blud., H			
ore	or of H		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Discemetery, c	position (Name of rematory or other place)	Date	20c. Location - City or T	own, State
altimore,	Pag tment tant:		4 Donation 5 Other (Specify) Angel Hi			avre de Gra	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "neturel", or items 23a or 28a-f show any injury or other traumatic event. The Medical Examinar must be notified at ODEs.	6	21. Signature of Funeral Service Licensee	22. Name and Address of Facility itchell-Smith Fune 23 S. Washington,	ral Home Havre de	, P.A. Grace, MD	21078
		(	23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardia	c or respiratory arr	est,	Approximate Interval Between
5	Physician		fmmediate Cause (Final disease or condition				Onset and Death
r	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	DELINE TAUD	0 E		0.4
		e.	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):	RENAL FALLUI			49K5
5	nsit	in	cause. Enter Underlying Cause (Diseese or injury				
,	execun and ial-tra	Examin	that initiated events resulting in death) Last c Due to (or as a consequence of):				
58760,	icate be executed physicien and s the burial-transit	dicai	d				
_			fF FEMALE:				
P.O. Box	Attending Physician: The law requires thet the death certific in death. If death. ector: Atter this certificate hes been signed by the attending p by the funeral director, page 2 should be detached for use as by the funeral director.	Physician/M	23b. Was decedent pregnant in the cast 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 □Ectopic pregnancy		23d. Date of deliv	ery Dav Year
<u>.</u>	the all	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	Other (specify)		Month	Day rear
	het the	Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did tot	bacco use contribute to	the cause of death?
ds,	signé d be	d by	HYPERTENSION	y and a second second second second			bably 4 Unknown
Ö	w require been si should i	Completed			24a. Was a	n 24h Were aut	opsy findings available
B B	he la e hes age 2	mc			autops perforr	med? prior to co	ompletion of cause of
<u>ta</u>	nn: T tificat tor, pe	Ф	25. Was case referred to medical	26 Place of Dec	1 ☐ Yes 2 ath (Check only on		2∐ No
<u> </u>	ıysician: The lav is certificate hes director, page 2	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   R/Outpat	Other	- 10 - 10 - 10 - 10 - 10 - 10 - 10 - 10	ence 6 □Other (Speci	ıfv)
0	neral	Ë	27. Manney of Death  1		28d. Describe ho	ow injury occurred	
Sio	eath. or: A	catle	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No			
Division of Vital Records,	5 # # S	Certification;	4 Homicide determined 28e. Pface of fnjury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (St City or Town	treet and Number or Rui n, State)	ral Route Number,
Ц	pitei ours a aral [		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	2th appured at the time, date and class	and due to the se	(-)	
	To the Hospitei or Attendi within 24 hours after death. To the Funaral Director: A completely filled in by the fi	edical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check ord) 2 Medical Examiner: Un the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	irred at the time, d	ause(s) and manner as: ate and place, and due	to the cause(s)
	To th within To the	Me	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month)	, Day, Year)
	/		* Kleyerstoin Mo	12020154		2/30	106
	4		30. Name and address of person who completed cause of death (ftem 23a) (Typ	e, Print)		0,00	104
	<u></u>			nion Ave., Havre	de Grace	e, MD 21078	}
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature	Localle 1			
	negistr	1	APR 1 2 2006 American A.	100			

			1 - For State Registrar	State of Maryland	/ Department of He		ygiene	11500
			Decedent's Name (First, Middle, Last)			2. Date of D	Death	3. Time of Death
	Physic /Medi		DOROTHY		BROWN	APR11	Day Yea	
sai.	Exami		4a. Facility Name (If not institution, give s	, 1	4b. City, Town, or L	ocation of Death	4c. County of D	eath
			5. Social Security Number 6. Sex			+LTIHORE	1	IA
	Funeral Director			M 2XF	t birthday) If Under 1 Year  Yrs. Months Days		Day, Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent			JAN.	11,1991	IARYLAND
	death with the Maryland me 23a or 28a-f ehow r must be notified at	_	10a. State 10b. County	10c. City,	Town or Location			10d. Inside City Limits
	8a-f	cto	MARYLAND NI	A	NAL XOAL	TIMORE (	CITY	1/Q Yes 2 □ No
	with the	Director	10e. Street and Number	00-1-	10f. Zip Code	1.01/	10g. Cipizen of What	Country?
	eath se 23	by Funerai	11. Marital Status	R GROVE S/ 2. Was Decedent Ever in U.S.	KEET O	21216	45	
	iter d	Ë	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 1€ No	If Yes, specify Cuban,	panic Origin? (Specify Yes or the Mexican, Puerto Rican, etc.)	14. Hace - A Black, W	merican Indian, hite, etc.
99	urs a		3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🗷 No	Specify:	Specify:	BIACK
5-0036	s 1 end 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene. Item 27 is marked other than "natural", or iteme 23e or 28e-f show other traumatic event, if a Medical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade		16a. Decedent's Usual Occupation	on	16b. Kind of Busine	ss/Industry
2	of the state of th	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done dui life. DO NOT use retired)		11	
2	led w tygier her th		8TH GRADE		HOUSEKE		HOTEL	<u> </u>
anc	ntal Hed of	Be	17. Father's Name (First, Middle, Last)	WESTER A	1	8. Mother's Name (First, Midd.		12 = 0
Z	hould d Me mark matic	၉	19a. Informant's Name/Relationship	LVESTER D	19b. Mailing Address (Street and	CATHERIN		NCER.
Mary	end 2 s lealth an m 27 is		PATSY CHAMBERS		2533 E. M			
ā	f Healthean other		20a. Method of Disposition	120b. Plac	e of Disposition (Name of	Date	20c. Location - City	or Town, State
Baltimor	Pages ent of nt: If it		1 ☐ Burial 2 SCremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	netery, crematory or other place) TRO CREMATOR	2.1114-12-01-	BATIN	pr des
ati	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service License	1111	22. Name and Address	of Facility,	NACITY FIL	NEDAL HOME
m	Depa Impo any in		Wietuch N	William	0 39485	of Facility H. BROC -ULTONAVE.	BAITO, M.	0.21217
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death.	Do not enter the mode of dying,	such as cardiac or respiratory	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	SEP	313			Onset and Death
	/Medical		resulting in death)	Due to (or as a consequer				22 DAYS
	Examiner		Sequentially list conditions.	Due to (cr as a consequen	STATIC 24	ING CANCI	ER	UNKNOWA
å	pe tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					21
	be executed ician and burial-transit	хап	that initiated events cresulting in death) Last	A 12TE 12103  Due to (or as a consequer	CLEROT C	HEART DIS	5 EASE	
8760	ate be e hysician the buria		l.					
687	ficate physis the	edicai	d					2222
Вох	death certifica attending pt for use as t	N N	IF FEMALE: 23b. Was decedent pregnant	ic. If yes, outcome of pregnanc			23d. Date of d	lelivery
m.	death e atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 🖔 No	1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of deat			Month	Day Year
P.O.	at the de by the a	hys	9 🗆 Unknown	9□ Unknown				
S,	es tha igned be del	by	Part II. Other significant conditions con-	ributing to death but not resulti	ng in the underlying cause given	in Part I. 23e. Did	tobacco use contribute	to the cause of death?
ord	w requir been si should	ted	- ANAEMIA		1		Yes 2□No 3□	Probably 4 DUnknown
Division of Vital Records,	e faw r has be je 2 sh	Completed	- enzonic	OBSTRUCT!	VE ZUNG ?	D158456 24a. Wa	s an 24b. Were	autopsy lindings available
<u>=</u>	The tage	Son		ZLAZCEM14		perl	ormed? death' 2₽0No 1 ☐ Yo	completion of cause of
/ita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			6. Place of Death (Check only	one	
of \	Physi this c	은	1 Les 5 140	ospital:	/Outpatient 3□ DOA Other:	4 ☐ Nursing Home 5 ☐ Res	idence 6 Other (Sp	pecify)
Ę	ding I h. After funer	on	27. Manner of Death 1 ØNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury at Universe Work?	28d. Describe	how injury occurred	
Si	Attendideath.	lica	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home		s 2 No	(Street and Number or	Dural Davida Maria
ĕ	of or Attendation of a ster death   Director: , do in by the f	Certification:	4 Homicide determined	building, etc. (Specify)	s, tarm, street, tactory, onica	City or To	own, State)	Hurai Houte Number,
	pite ours oral		29a. Certifier 1 Certifying Physi	cian: To the best of my knowle	dge, death occurred at the time,	date and place, and due to the	cause(s) and manner	as stated.
	To the Hos within 24 h To the Fun completely	edicai	one) Z Medical Examin	and manner stated.	andor investigation, in my opini	on, death occurred at the time	date and place, and de	ue to the cause(s)
	To the P within 2 To the F complete	×	29b. Signature and title of certifier	1 000	29c. License ni		29d. Date signed (Mo	
	5			-Stalon v	D D 2	3300	APRIL	05 2006
	ix	31	30. Name and address of person who con	pleted cause of death (Item 23	Ba) (Type, Print) 130N	BELOURS !	KUBP.	
	\		SUDKIR, D.	MATE2.	2000 W, BA2	TO. ST. BA	-2TD. MAS	0.21223
	Sta		31. Date filed (Month, Day, Year)	2. Registrar's Signature	Acord 8			

-02365		Ct				Print in					iono			
na, Arturo		ી 1- For State	ate of i	viaryiano		rtment o		anu	wenta	п пууг		20	06	111.0
		Registrar			Cer	lineale of	Dealli			10.				1140
Physiciai edical Examin		1. Decedent's Name (First, Middl Arturo Luna		avo							Date of Dea Month April 6, 2	Day Yea		3. Time of Death 7:18
	ı	4a Facility Name (if not institutio			er)		4b. City, Tov		cation of E		tpill 0, 2	4c. County	of Death	
Funeral	-	Social Security Number	6 Sex	7.	Age (In yrs. la	ast birthday)	If Under		If Under 2	24Hrs. 8	. Date of B	irth (MM/DD/YYYY	) 9. Birth	place (State or Foreign
Director		932-77-8072	1X XM	2 F		34 Yrs		Days	Hours	Min.	08/0.	4/1971	Pe	
٨		Usual Residence of Decedent	71-73		100 City	Town or Locat	ilan				00/0.	4/12/1		10d Inside City Limits
1 10 w an		10a. State 10b. County MD				altimo								1 Yes 2 No
ylanc -f sh	ğ					arcimo	10f. Zip C	- d-				10- Citizen of M	hat Carret	23
ne Mar or 28a fied at	Director	10e. Street and Number 104 N. Montfe	ord a	Ave.				224				10g Citizen of WI Peru	nat Count	1 <b>y</b> ?
	Funeral [	11. Marital Status  1 X Never Married 2 M		Was Decede Armed Force	s?		as Decedent es, specify (						e - Americ e, etc.	an Indian, Black,
after des al", or i		3 Widowed 4 Div	orced If Ye	Yes s, Give Year pates:	2 <b>XX</b> No		Yes 2	_		_		Specify:	Whi	
hours natur	ed	15. Decedent's Education (Spe				16a. Deceder during					work done 16b. Kind of Business/Industry			
21215-0036 uld be filed within 72 Mental Hygiene marked other than 'e event, the Medical	Completed by	Elementary/Secondary (0-12) 12th	12th Self-Employed (							Const	ruti	.on		
15-0 filed w Hygie d othe	Ŝ	17. Father's Name (First, Middle,	Last)									Maiden Surname	)	
121 Id be i Aental narke event	ш,	Alfredo Luna  19a. Informant's Name/Relations	nin /Tyne I	Print \		19h Mailin	a Address	1			ia Bi	CaVO Imber, City or Tow	n State	Zin Code)
MD 2 nd 2 shou alth and M m 27 is n	Ě	Jorge Luna		rothe	r		_					alto.MD		
Health		20a. Method of Disposition			20b. I	Place of Dispos crematory or ot	sition (Name				ate	20c. Location		
Pages ent of int: If		1 X Burial 2 Cremation 4 Donation 5 Other Sp	t-man-1	temoval from	State	VAK					2-06	Lima,		
Baltimore, permit Pages I an Department of Hea Important: If iter injury or other tra		21. Signature of Funeral Service		Phan	-h	22.1						Chavis, Lto.MD		
Physician		23a. Part I. Enter the disease, or failure. List only one caude			ed the death.							rest, shock, or he		Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. ,			Cardiov	rascular	dise	ease					Death
	_	Sequentially list conditions,	b.				2							
	nine	if any, leading to immediate cause. Enter Underlying Cause	c.	to (or as a co	nsequence o	t):								
vecuted n and transit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due t	to (or as a co	nsequence o	f):								
oe execute cian and rrial - tran	dical	X UNPENDED		MENDED it	:em#1,23	Ba,PII,27	,perÆ,	G854,	,4/15/0	06 TT				
760 Treate b	Me.	IF FEMALE: 23b. Was decedent pregnant in the	23	c. If yes, outo		nancy			-			23d. Date of Month		Vaas
Box 68760  e death certificate be the attending physical for use as the bu	Physician/Medical	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregna 4 Pregnant at time of death 5 Other (Specify)							regriancy		World	Da	ay Year	
Bo he dea y the a hed fo	λy.	Part II. Other significant condit	9			esulting in the	undorlying c	auco aive	on in Part		220 Did	tohacca usa contr	ibuto to th	ne cause of death?
P.O	ò	Seizure disorder		inbating to de	atti but not i	esulting in the	anderlying o	ause give	CIT III F CIT		1 Y			ably 4 Unknown
Records, The law require ficate has been si	Completed										24a Was			ppsy findings available
ecol ne law te has l	dim										auto perfe	ormed?	death?	mpletion of cause of
n: Th Tifical or, pa	ပိ	25. Was case referred to medica					26	.Place of	f Death (C	heck only		2 140 1	V 103	2 100
Vita ysicia his cer direct	Ö	examiner?  1 ✓ Yes 2 No	Hospit	tal: 1 Inpa	atient 2	ER/Outpatien	t 3 DO	A Ot	ther <sub>4</sub> N	Nursing H	ome 5	Residence 6	✓ Other.	Scene
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transi	on: T	27. Manner of Death  1 X Natural 5 Pend		28a. Date of I (Month, Da	njury y,Year)	28b. Time of	Injury 28		at Work?		d. Describe	how injury occurr	ed	
'iSiO	icati	2 Accident Inve	stigation	28e. Place of	Injury - At h	ome, farm, stre	et, factory, c				. Location	(Street and Numb	er or Rura	al Route Number, City
Div spital or sours aft	Certification:	4 Homicide dete	rmined	(Specify)							or Town,	State)		
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	miner:On	the basis of e	xamination a							use(s) and manner e and place, and c		
To COI	Me	29b. Signature and title of certific		manner state	ad.		29c. I	icense r	number			29d Date sign	ed (Mon	th, Day, Year)
أقر		Caled	l t	Ha	el,	20		O.C.M.	.E.			April 6, 200	06	
15442		30. Name and address of person Carol Allan, MD As		leted cause of		23a) 111 Penn	Street R	altimor	e MD 2	1201				
Sta	ite	31. Date filed (Month, Day Year)		32. Ress	त्रागान्दा trar's Signatu		oucet, be	2101101	O, 1010 Z	201				
Registr	ar	APR 1	2 200	16 Se	sur .	15 Ag	SHE)							
DHMH 17 Rev 1/20	01					ORIGÍNA	<b>AL</b>							

DHMH 17 Rev 1/2001 OCME 10/2003

			1 - For Registrar	State of		nd / Dep		lealth and	Mental Hy		06	1 1 4 0 2
8	Physic	an	Decedent's Name (First, Middle	Last)					2. Date of De Month	ath Day	Year	3. Time of Death
	/Medi			LEY		BARSA			04	06	2006	11:55 A M
	Examir	ner	4a. Facility Name (If not institution,			nn n	4b. City, Town, o		ath		inty of Death	
			FOREST HILL HEA  5. Social Security Number			last birthday)	FOREST	HILL If Under 24 H	rs. 9 Date of Rin	1	RFORD	ologo /Ctoto ou Fourier
	Funeral Director		110-01-6830 Usual Residence of Decedent	1 <b>X</b> M 2□F	92	Yrs.	Months Days	Hours M				place (State or Foreign htry) York
	yland		10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation				1	Od. Inside City Limits
	8a-f si	ctor	Maryland Harf	ord	Abe	erdeen		*				1 ☐ Yes Ž No
	with the	급	10e. Street and Number				10f. Zip Code				of What Cour	ntry?
	ss 23	eral	602 Shirley D		nat Francia II	10 10	21001		/2- // \/	USA		
36	be filed within 72 hours after death with the Maryland tal Hyglene. d other than "natural", or itams 23a or 28a-f show event, ita Mudical Ever it ar must be rectified at	y Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Deced Armed Forc 1 Tes 2 If Yes, Give	es?		was Decedent of H If Yes, specify Cub. 1 ☐ Yes 2 💢 No		(Specify Yes or No erto Rican, etc.)	-	Race - Americ Black, White,	
Ö	hours tural',	ed by	3 XWidowed 4 □ Divorced	Year or Date	os:						whi	
75	in 72 n "nai	olete	15. Decedent (Specify only highest	grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	ation during most of w d)	vorking	16b. Kind o	f Business/In	dustry
212	e filed within all Hygiene. Other than "vent, the Med	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)		rineer	-7		Alumi	nium M	Manufacture:
pu	be filed stal Hygi of other event, I	Bec	17. Father's Name (First, Middle, L	ast)				18. Mother's N	ame (First, Middle,			
ylaı	should by nd Menta marked matic ev	To	Barsam (U/K	) Bars	amian			Miria	n (U/K)	Chou	ıldjiar	1
Maryland 21215-0036	nd 2 shouth and 27 is my		19a. Informant's Name/Relationsh Christopher Bar						Rural Route Numbe t, Bel Ai			Code) 21014
ē,	f Healitam		20a. Method of Disposition	-	20b. F	Place of Dispo	sition (Name of		Date		on - City or To	
E	Page net o nt: if		1 🌠 Burial 2 □ Cremation 4 □ Donation 5 □ Other (Sp		3.09	-	natory`or other plac 1em. Gard		11-06	Aberde	en. Ma	aryland
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: if Itam 27 is marked any injury or other traumatic ex		21. Signatore of Juneral Service L	icensee	1				ome, P.A.			-7
	40280		23a Part 1 Enter the disease or o	omplications the agus		173	17 Cokes	bury Ro	ad. Abino	idon. M	arvlar	
A ST	Priysician /Medical	(t)	23a. Part1. Enter the disease, or o shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause: a	line.	Lutic	. Ch	1.1	www.	rrest,		Approximate Interval Between Onster and Death
8760, Com	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disasse) or jury that initiated events resulting in death) Last	bb.	as a consequence as a c	uence of):	4					
O. Box 6	uires that the death certific signed by the attending p Id be detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		n 2 ☐ Feta: t at time of d	death 3	Ectopic pregnancy Other (specify)			1	Date of delive	ny Day Year
ر. ص	s that	by Ph	Part II. Other significant condition	s contributing to dead	but not resi	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	obacco use co	ontribute to th	e cause of death?
Records,	w require been sig should by		14 Cherose	lentie (	kulu	Vascul	120	Seech	150	es 2□No	3 Prob	ably 4 □Unknown
000	aw requisible	plet					- (*	,	24a. Was		b. Were autor	osy findings available
m m	Physician: The lav r this certificate has ral director, page 2 a	Completed								rmed?	prior to con death?	npletion of cause of
Ita	striffican: ctor,	Bec	25. Was case referred to medical examiner?					26. Place of De	eath /Check only o	-	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
<u> </u>	hysic his co	္ရ	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inp		ER/Outpatien	t 3 DOA Oth	er: 4 Nursing	Home 5 ☐ Resid	dence 6 🗆 C	Other (Specify	)
Division of Vital	ing P	ö	27. Manner of Death  1 ☑Natural 5 ☐ Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	28c. injun Worl	at k?	28d. Describe h	now injury occ	curred	
Sic	Attending r death. ector: After by the fune	Icat	Z Accident investiga 3 Suicide 6 Could no	t bo	1-1			Yes 2 □ No				
Σ	2 5 5 6	Certification:	4 Homicide determin	ed 288. Place of building,	etc. (Specify	ome, tarm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Nui in, State)	mber or Rurai	Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled is	Medical	one)	Physician: To the be caminer: On the basi and manner	s or examinar	wledge, death tion and/or inv	occurred at the timestigation, in my of	ne, date and place pinion, death occ	ce, and due to the courred at the time, o	cause(s) and date and place	manner as sta e, and due to	ated. the cause(s)
	To To t	2	29b. Signature and title or certifier	7/			29c. License	number	3	29d. Date sigi	ned (Month, L	Jay, Year)
			100	2220	FA	P	1439	550	/	HARTL	. /	2006
	15		30. Name and address of person w DR. PETER LOPRE	no completed cause o				י עאנג פ		MD 0	10/0	
Carried States	Sta	te	31. Date filed (Month, Day, Year)		strar's Signar	4		I WAL,	FUGEWOOD,	<u>rib 2</u>	1040	
2 W	Registra	ar	APR 1 2 20	NG Brown	e sk	ture	a land					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Year 5 PM 06 2006 Lambert Henry Babec /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Citizens

5. Social Security Númber Haure De Grace
If Under 1 Year | If Under 24 Hrs. arford Nursing 8. Date of Birth (Month, Day, Year) Apr. 23, 1925 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2□ F 218-18-4472 80 Yrs. Maryland **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or Items 23a or 28e-f ehow Examiner must be notified at 1 ☐ Yes 2 No Harford Havre de Grace Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21078 USA 122 Darlington Road Pages 1 and 2 should be filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛣 No þ 3 ☐ Widowed 4 ☐ Divorced "naturel", Completed Is marked other then "natur reumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 Maintenance Mechanic Civil Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Peter (MMN) Babec Veronica (MMN) Pincher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any injury or other treu once. Doris Babec/Wife 122 Darlington Road, Havre de Grace, Maryland 21078 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Hillton Serv. Corp. 4-22. Name and Address of Facility Towson, Maryland 4-11-06 21. Signature of Foneral Sorvice Licensee McComas Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate \* Ull Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arter oronary /Medical Due to (or as a consequence of) Examiner emention Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of). Physiclan/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year Month 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Junknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 2 10 No 1 Yes 1 Yes 2 2 No To the Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Director: After that in by the funeral 28b. Time of 28a. Date of Injury (Month, Day Year) 27 Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exemplaer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature d title of certi DOO 62903 04/07/06

Registrar

State

31. Date filed (Month,

1 2 2006

Babec, Lambert

freek

Sunion

Ave Harre De Grace, MD

on who completed cause of death (Item 23a) (Type, Print)

319 SU 3 Registrar's Signature 06-02383 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Cooley, Teresa 1- For State Certificate of Death Rea. No. Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Da April 7, 2006 Medical Examiner Theresa Coolev Υ. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Bon Secours Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8 Date of Birth (MM/DD/YYYY) 9. Birtholace (State or Foreign 6 Sex **Funeral** Country) Months Davs Hours Director 214-84-6812 1 M 2 X F 43 07-31-1962 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No s 23a or 28a-f shov e notified at once. 28a-f show MD Baltimore hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 Dolphin Street 21217 USA Funeral 11, Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 X Never Married Married Yes 2 X No 9 Divorced If Yes, Give Year or Dates: 1 Yes 2 X No specify: Specify: **Black** ð 15 Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed durina Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 inent of Health and Mental Hygiene ant: If item 27 is marked other than "I or other traumatic event, the Medical E most of working life. DO NOT use retired) **Baltimore**, MD 21215-0036 10 Domestic Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ernest Cooley Shirley Perkins

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Latarsha Payne/Daughter 639 Smithson Street Baltimore, Maryland 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State permit. Pages
Department o
Important: I 4 Donation 5 Other Specify: 4-14-06 Baltimore, MD Trinity Cemetery 22. Name and Address of Facility Signature of Funeral Service Licensee James A. Morton & Sons F.H., Inc. nter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart 1701-31 Laurens St. Baltimore, Maryland 21217 Approximate Interval **Physician** Between Onset and List only one cause on each line /Medical Cocaine and narcotic intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last certificate be executed and item#1,23a,27,28a-f,perME,g855,5/10/06 TT sician/Medical X UNPENDED X AMENDED physician the burial -Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth Ectopic pregnancy Fetal death Month Day for use as Pregnant at time of death 5 Other (Specify) Hospital or Attending Physician: The law requires that the death 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? 1 ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other this 1 🗸 Yes 2 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) Natural Director; / 1 Yes 2X No Pending unk Fnd 4/7/2006 Fnd 1:30 AM 2 filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3023 WeSTWOOD AVE. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide or Town, State) determined (Specify) Baltimore, MD Homicide Found at residence Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started

2:07

DC

Death

2 No

29d Date signed (Month, Day, Year)

April 7, 2006

State Registrar

Medical

31. Date filed (Month Pay Year) APR 12

n

mus

30. Name and address of person who completed cause of death (Item 23a)

29b Signature and title of certifier

Ling Li, MD



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E

DHMH 17 Rev 1/2001 OCME 10/2003

			For	State of Ma	aryland /			Health and M	Mental Hy	giene	,	1 1 1 0 12
			1 → State Registrar			Certi	ficate of	Death		Reg. No.	Ju	1405
	Physici	an	1. Decedent's Name (First, Middle, Las						2. Date of De Month	Day	Year	3. Time of Death
	/Media	cal	Thelma S. C	Coster			h City Town	as Lagation of Depth	April	11, 2 4c. County	006	1:10 P M
	Examir	ier	Gilchrist Cente	,		1	Towa	or Location of Death			timo	ካ 0
	Funeral		5. Social Security Number 6. So		e (in yrs. last b		if Under 1 Year	If Under 24 Hrs.	8. Date of Bir		9. Birthr	place (State or Foreign
	Director		212-01-9478	□M 20X(F	90	Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da March	18.1916	Mari	iland
	p ,		Usual Residence of Decedent		100 City Tow		No.					104 1-14- 02 11-2-
	aryle ehov	7	10a. State 10b. County		10c. City, Tov							1 ☐ Yes 2 ☑ No
	the M	ecto	Maryland Baltimor	Le		ваи	imore 10f. Zip Code			10g. Citizen of N	Mhat Cau	
	ath with the Maryler 23a or 28s-f ehow	Ē	6825 Campfield	Road. Ant	. 6D			21207			S.A.	itt y r
	illed within 72 hours after death with the Marylend Hygiene. Hygiene Hygiene then "natural", or items 23s or 28s-f ehow ont, the Medical Examinar must be nutilised at	Be Completed by Funeral Director	11. Marital Status	12. Was Decedent		13. Wa		Hispanic Origin? (Sp pan, Mexican, Puerto	pecify Yes or No		e - Ameri	can Indian,
ဖ	after or ite	Fur	1 Never Married 2 Married	Armed Forces?	No		es, specify Cub ]Yes 2.2X No		o Rican, etc.)		ck, White,	
03	ours iral;	d by	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1	Tes ZZANO	Specify:		Specifi	v: WIL	
<u></u>	natu	ete	15. Decedent's Ed (Specify only highest grad	ucation de completed)	168	(Give kir.	it's Usual Occup ad of work done NOT use retire	during most of work	king	16b. Kind of B	usiness/In	dustry
21215-0036	withir ene. then	d mc	Elementary/Secondary (0-12) 5th Grade	College (1-4or 5	5+)		nemaker	ru)		0	wn H	ome.
2	be filed ital Hygi id other event, I	Ö	17. Father's Name (First, Middle, Last)					18. Mother's Nam	ne (First, Middle			
<u> </u>	should be nd Mental marked o	5 B	George Sturged	n				Sophia	$B\omega$	iger		
Maryland	d 2 should be f th and Mental P 7 ie marked of traumatic eve	_	19a. Informant's Name/Relationship (7	Type, Print)				t and Number or Ru			State, Zip	Code)
	C = 44 F		Mr. Scott Coster	(son)				Drive, Bo		MD 210	13	
ore	Sign		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place o	of Dispositi ery, cremat	on (Name of lory or other pla	109)	Date	20c. Location -		
3	Pag tment tant:		4 ☐ Donation 5 ☐ Other (Specify	)	Balti	_	Cemete					Maryland
m Baltimore.	permit. Page Depertment of Important: if any injury or		21. Signature of Funeral Service Licen	500	•	22. N	lame and Addre	ess of Facility Sci Wir Rd., 1	himunek	Funeral	Home 2123	
0,6			23a. Part1. Enter the disease, or comp	plication, that caused	the death Do						21250	Approximate
			shock, or heart failure. List only of Immediate Cause (Final	one cause on each lin	10.	not office	ino modo or ay	ing, dadir ad dardiad	or rospiratory a	11031,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	a consequence	of):					-	Strys
-	Examiner			Can			lar o	les las e				lerathe
2006	17	ner	Saquantially flet conditions if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequence		-					0-04711-05
Z	and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
- •	licate be executed physicien and s the burial-transit	E	rosuming in doubly cast	Due to (or as	a consequence	of):						
11/	physicate the the the the the the the the the t	dicai		. d								
. کا ×	eath certifii attending f		IF FEMALE:	23c. If yes, outcome	of pregnancy			*		23d Da	te of delive	201
O B	death certif e attending ed for use as	by Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		topic pregnanc ther (specify)	y			nth	Day Year
0	t the c by the achec	hysi	9 Unknown	9□ Unknown			,					
2 °	law requires that the de as been signed by the 2 should be detached	y P	Part II. Other significant conditions of	ontributing to death b	ut not resulting	in the unde	orlying cause gr	ven in Part I.	23e. Did t	obacco use cont	ribute to t	ne cause of death?
Ξğ	en sig	ed							1 🗆 '	Yes 200 No	3 Prot	abiy 4 Unknown
500	e law re has be je 2 sh	Completed							24a. Was	an 24b.	Were auto	psy findings available mpletion of cause of
28	ate Th	Con							perfo 1 ☐ Yes	rmed?	death?	
/- ita	ysician: Th	Be	25. Was case referred to medical examiner?	tteeritet			I ou	26. Place of Dea	th (Check only o	one)		
\ \~\overline{6}	% v 5	5	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatie		utpatient Time of	3 DUA		ome 5 Resi	dence 6 Oth	1-1-	Prospece
7 5	ding h. After tuner	tion	1 ANatural 5 ☐ Pending	(Month, Day		Injury	28c. Inju Wo	ryat krk? ]Yes 2∐No	200. Describe	now injury occur	90	
+C	Attending r death.	fica	3 Suicide 6 Could not be		ury - At home, fa	arm, street			28f. Location (	Street and Numb	er or Rura	I Route Number,
S	# # E E	Certification;	4 Homicide	building, etc	c. (Specify)		,		City or To	wn, State)		
9	Hospital		29a. Certifier 1 Pertifying Phy (Check only 2 Medical Exam	ysician: To the best	of my knowledg	e, death o	ccurred at the ti	ime, date and place,	and due to the	cause(s) and ma	nner as s	tated.
	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	one)	niner: On the basis of and manner sta	ted.	novor inves						
	To t To t	2	29b. Signature and title of certifier	А			29c. Licen:			29d. Date signe		Day, Year)
	.)		The can	Lans			058	303		Mahari	V1 2	
	4		30. Name and address of person who o	completed cause of d	eath (Item 23a)	(Type, Pri	our les	. 84 1	Jarlu	o ms	2120	rd
	Sta	te	31. Date filed (Month. Day, Year)	32 str	ar's Signature			10	, , , , , ,	w ···	-,	T
	Registr		APR 1 2 200	06	as It	6700	de					

		For Stete Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artment <i>rtificate</i>			nd M	ental Hy	ygien Reg. N	Comp. Total	6	1406
Diam'r.		1. Decedent's Name (First, Middle, L.	ist)							2. Date of D Month		ay	Year	3. Time of Death
Physic /Medi		Grover Allen Com	bes							April	7,	2006		1:45 p M
Exami	ner	4a. Facility Name (If not institution, gi		iber)		4b. Cily, T	_	Location of	Death		4	c. County		
		1704 Shirley Ave		7 4 //	Jane bink day	If Under 1	Jopi	pa. If Under 2	A Hrs	9 Date of B	i adda	Hari		alana (State or Foreign
Funeral Director			Sex 1 M 2 F	7. Age (in yrs. 80	. last birthday) Yrs.		Days	Hours	Min.	8. Date of B (Month, D Sept.	ay, Yea	1925	COL	place (State or Foreign intry) rginia
		Usual Residence of Decedent	X	00						sept.	17,	1723	V 1	Iginia
yland		10a. State 10b. County		10c. C	ity, Town or Lo									10d. Inside City Limits
a-fs	ctor	Md. Harfo	rd 			J	oppa	a 						1 ☐ Yes 2 ☐No
ith the or 28	Olre	10e. Street and Number				10f. Zip (						itizen of W		intry?
ath w	ral	1704 Shirley Ave					108					J.S.A.		
Baltimore, Maryland 21215-0035 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ira Madical Examinat Lembilised at any once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married	12. Was Dece Armed For 1 Tes If Yes, Give	ces? 2 🔯 No e	1	Was Decede If Yes, speci 1 ☐ Yes 2		spanic Orig n, Mexican, Specify:	in? (Spe , Puerto	ecify Yes or N Rican, etc.)	10-		c, White	ican Indian, , etc. hite
fural hour	q pe	3 ₩ Widowed 4 Divorced	Year or Da	ites:	16a Dece	dent's Usual	Occupa	tion			16h	Kind of Bu	siness/li	ndustry
15- in 72	Completed	(Specify only highest g	ade completed)		(Give	kind of work	done d	uring most	of worki	ng	100.	Mila of Du	3111033411	ladatiy
vith iene.	mo m	Secondary (0-12) 3 years	College (1-	-4or 5+)	ca	arpent	er					const	ruc	tion
other,	BeC	17. Father's Name (First, Middle, Las	t)					18. Mother	r's Name	(First, Middl	e, Maide	n Sumame	9)	
Menta by Alenta	To B	Millard Combes						E1:	izab	eth Du	nfor	rd .		
Maryland 21215-0036 nd 2 should be filed within 72 hours af alth and Mental Hygiene. 27 is marked other than "natural", or riraumatic event, the Marical Exam		19a. Informant's Name/Relationship Margaret Combes/				•				Joppa,	-			ip Code)
altimore, mit. Pages 1 ar partment of Hea portant: If item: y injury or other		20a. Method of Disposition	70		Place of Dispo	sition (Name	e of ner place	9)	С	ate	20c.	Location -	City or T	own, State
Page Page nent c	l .	1 Burial 2 ☐ Cremation 3 Cremation 3 ☐ Other (Spec		Hi	ghview	Mem.	Gdns	s. 4	4/10	/2006	Fal	1stor	1, M	d.
Balti permit. Departr Importa		21. Signature of Funeral Service Lice	insee (	1	22		unel	k Fune	eral	Home				Inc. 21014
		23a. Part1. Enter the disease, or con shock, or heart failure. List on	nplications that ca	used the dea	th. Do not ent	er the mode	of dying	g, such as o	cardiac c	or respiratory	arrest,	<del>\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ </del>	10.5	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition			= 1+05	Mr.	FAIC	ine						Onset and Death
/Medical		resulting in death)	Due to (c	or as a conse	equence of):  15/12/E	1	7,6							
Examiner		Sequentially list conditions.				HEN	27	MH	nse					yars
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a conse	quence of):									
xecut and Il-tran	Examin	that initiated events resulting in death) Last	c	or as a conse	guence of):								-	
58760, ficate be executed physician and sthe burial-transit	a E													
687 ificate g phys as the	edlcal	1.0	d											
	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			Te						23d. Date	of deliv	very
Geath death death death	Physician/M	in the past 12 months? 1 □ Yes 2 □ No	4☐Pregna	nth 2 □ Fet ant at time of		∃Ectopic pre ∃ Other <i>(spe</i>						Mon	th	Day Year
or at the by the tache	hys	9 Unknown	9□ Unkno	wn						6				
S, F res tha rigned be det	by F	Part II Other significant conditions	contributing to de	ath but not re	sulting in the u	nderlying ca	use give	en in Part I.						the cause of death?
Cord w require been si should I	ted	VIMSERES								11	Yes	2 🗆 No		
Hecc	Completed									24a. Wa aut	opsv	24b. V	ere aut	opsy findings available ompletion of cause of
The The ate h	Con									per 1 ☐ Yes	formed?	to 1	eath? □ Yes	2□ No
/ita	Be	25. Was case referred to medical examiner?	14inde				Oth		of Death	(Check only	one)	- 4		
Of Physical this call direct	မ	1 ☐ Yes 2 No			ER/Outpatier		_	4 🗆 1401	-	me 5 He				ify)
on of Vital Reding Physician: The India Physician: The India Physician The India Physician Physi	lon	27. Manner of Death  1 SNatural 5 □ Pending		h, Day Year)	28b. Time o Injury	M 40	c. Injury Work	res ∕es 2∐N	1	28d. Describe	a HOW III	july occurre	ou.	
VISION Attention of the octor:	Certification:	2 Accident investigati 3 Suicide 6 Could not 4 Homicide determine	28e. Place	of Injury - At h	nome, farm, str ify)					28f. Location City or To			er or Rui	ral Route Number,
Diy To the Hospital or within 24 hours afte To the Funeral Dir completely filled in		(Check only /2 Medical Exe	hysicien: To the miner: On the ba	sis of examin	owledge, deat ation and/or in	h occurred a	t the tim	e, date and	d place, a	and due to the	e cause e, date a	(s) and mai nd place, a	nner as nd due	stated. to the cause(s)
thin 2 the the mplet	Medical	29b. Signature and title of certains	and mann	er stated.		29c	License	number			29d. F	ate signed	(Month	. Day, Year)
To Visit		1007 1/1/	^				N.	284	3		1/1	PRIL		2016
1		20 Name and address to	nonmoleted	a of door the	m 22a) /T			•			V)	IVIIL	10	
5		30. Name and address of person who	2005 N	NC/ IV	ORILIG.	MA		190	MIL	HU	V	40		
St	ate	31. Date filed (Month, Day, Year)	32. B	g strar's Sign	ature	6	,							

DHMH 17 Rev 1/2001

ODIGINAL

-			1 - For State Registrar	State of I	Maryland		artment rtificate					giene Reg. No.	106	1407
3	Physici	an	Decedent's Name (First, Middle, La	•							2. Date of De. Month	ath Day	Year	3. Time of Death
	/Medi			ang							Apri1	10	2006	5:30 A M
-	Examir	ner	4a. Facility Name (If not institution, given Fairland Adven						Location of				ounty of Death	
		đ.			Age (In yrs. las		If Under		Spri:	_	R Date of Birth	Mo	ntgomer	
	Funeral Director			1 □ M 2 🛛 F	76	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da March	9, 19:	29 Kor	lace (State or Foreign etry)
3	ט		Usual Residence of Decedent				L				· icir cir	<i></i>	Z) ROI	
	anylar show	_	Mary Land Howa	rd	10c. City, 7				<b>.</b>				1	0d. Inside City Limits
	Ba-f	Director	rar y rana				Ellic	-	Ulty		····			1 ☐ Yes 2 X No
	with t	ä	10e. Street and Number	. 1 .			10f. Zip		010/0	,			of What Coun	itry?
	eath	era	2992 Mt. Etna Cir	12. Was Decede	nt Ever in 11 S	13	Was Deced		21043		octu Voc or No		.S.A.	an Indian
10	fler d	Funerai	1 Never Married 2 Married	Armed Force	is?	10.	Il Yes, spec	fy Cuba	n, Mexican	i, Puerto	ecify Yes or No- Rican, etc.)	- 14.	Black, White,	
030	72 hours after death with the Maryland natural; or Items 23a or 28a-1 show dical Examerer must be notified at	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	••		1 ☐ Yes 2	2 XNo	Specify:			Sp	oecify: K	orean
5-0	72 ho	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	dent's Usua	l Occupa	ition Jurina mosi	t of worki	na	16b. Kind	of Business/Ind	dustry
121	vithin ne.	I de	Elementary/Secondary (0-12)	College (1-4d	or 5+)	_	kind of word DO NOT us	_						
2	Hed v Hygie ther t	e Co	17. Father's Name (First, Middle, Last	)		bus	siness	Uwn		r'e Name	(First, Middle,		vn Busi:	ness
an	d be ental	To Be	Young Bong Chang	,				i			. Park	Maidell 38	mame)	
Maryland 21215-0036	should Mind Mind Mind Mind Mind Mind Mind Min	-	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	ng Address	(Street a	nd Numbe	er or Rura	I Route Numbe	er, City or To	own, State, Zip	Code)
Σ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other trsumatic event, the Madical Examinating must be notified at once.		Young Soon Park	(Daughte	er)	#482	gChang Korea	3C101	ng, K	wang	jimku,	350-1	Hyunda	ii Villart
ore	of He of He fitem		20a. Method of Disposition 1 □ Burial 2 [XCremation 3 [	Domeyal from Sta	20b. Plac	e of Dispo	sition (Nam natory or ot	e of her place	9)		ate	20c. Locat	ion - City or To	wn, State
Ĕ	Pag ment ant: I		4 □Donation 5 □ Other (Special			o Cr	emator	ſУ	4				sville,	
Baltimore,	Departiment important in Initial Initi		21. Signature of Funeral Service Lice	nsee	r .	22	2. Name and	d Addres	s ol Facilit	yWit2	zke Fun Colum	eral Į	Jomes I	pc.
			23a. Part 1. Enter the disease, or com	icic vv v									1d 2104.	Approximate
8760,	Physician by Medical Examiner by Street by Street By Str	icai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Fail Due to (or a	as a consequer	MU (ice of):	Thris	je						Interval Between Onset and Death
P.O. Box 68	The law requires that the death certificate be executed as been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Physician/Medical	IF FEMALE: 23b. Was decedent prefinant in the past 12 poinths? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		2 Fetal de at time of deat	ath 3	Ectopic pre					23d	. Date of delive Month	ry Day Year
	w requires that been signed t should be det	by	Part II. Other significant conditions	contributing to death	but not resultin	ng in the ur	nderlying ca	use give	n in Part I.			obacco use	/	e cause of death? ably 4 \(\sum \)Unknown
Division of Vital Records,		Completed									24a. Was a autop perfor	sy	prior to con death?	osy findings available inpletion of cause of
Zii.	ician: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Otho		of Death	Check only or	ne)		
o	Phys	٦.	1 Yes 2 No 27. Manner of Death	1 Linpa		/Outpatien			4 MUI		ne 5 Resid			)
on	ding th.	tion	1 Naturat 5 Pending 2 Accident Investigatio	28a. Date of Ir (Month, L	Day Year)	Injury	M	Sc. Injury Work	? es 2⊡ñ		ou. Describe n	iow injury or	curred	
/isi	or Attending Physicien: after death. Director: After this certification by the funeral director,	ertification:	3 Suicide 6 Could not b	e 28e. Place of I	Injury - At home	, larm, str					281. Location (S	Street and N	umber or Rura	Route Number,
Ö	s after s after of Director	Cert	4 Homicide	building,	etc. (Specify)		,				City or Tow	m, State)		
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical (	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Example	nysician: To the besing	ol examination	dge, death and/or inv	occurred a	it the time	e, date and inion, deat	d place, a	and due to the ded at the time, o	cause(s) and date and pla	d manner as sta ice, and due to	ated. the cause(s)
	To the H within 24 To the Fi complete	Me	29b. Signature and title of certified	and manner	otatou.		29c.	License	number			29d. Date si	igned (Month, L	Day, Year)
}	> - 0		→ XIIIX				P.	789	62				10, 20	
	4 . *1		30. Name and address of person who	completed cause of	f death (Item 23	Ba) (Type,		, - 1	0 6			Thiri	10, 20	
			Dr. Patell 230	9 Shoref	ield Ro	ad W	heato	n, M	lary1a	and 2	20902			
	Sta Registr	- 0	31. Date filed (Month, Day, Year)  APR 1 2 200	6 2. Regis	strar's Signature	Span	es.							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CORA LENA CUNNINGHAM 8:15A M APRIL 2006 6, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WESLEY HOME BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11 / 17 / 1908 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F 219-26-1812 97 Yrs. Director VIRGINIA Usual Residence of Decedent 10b. County 10a. State if Health and Mental Hygiene. Item 27 Ie marked other then "naturel", or Iteme 23a or 28e-f ehow other treumatic event. The Medical Exaction must be notified at 10c. City, Town or Location 10d. Inside City Limits MD N/A Director BALTIMORE CITY Y∏Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2413 COLLEGE AVENUE 21214 Was Decedent Ever in U.S. Armed Forces? 11. Maritaí Status 13. Was Decadent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes ZN No Il Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes XXNo Specify: ģ Specify: BLACK 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BALTIMORE CITY EXPORTOBOOL 0 8 Elementary/Secondary (0-12) Coflege (1-4or 5+) PUBLIC SCHOOLS 12TH EDUCATOR YEARS 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) GARRIE LEWIS REED LOTTIE GRESHAM or, Mic.

-drmit. Pages 1 and 2 shc.
Department of Health and M.
Important: If Item 27 Ieny injury or or. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 2 0 9 19a. Informant's Name/Relationship (Type, Print) ERNEST L. CUNNINGHAM / 2808 W. STRATHMORE AVE, BALTIMORE, MD SON 20b. Place of Disposition (Name of Date DULANEY VALLEY MEM. 4/12/06 GARDENS 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State TIMONIUM, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility HOWELL FUNERAL HOME 21207 21. Signature of Juneral Service Licensee 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or learn failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final diseast condition resulting in death) Stune Physician /Medical Examiner · Vasanen Disense Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 □Ectopic pregnancy Day 4 Pregnant at time of death Year 5 Other (specify) ed by the a detached t 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ā Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 Yes 1 ☐ Yes 2 No 2 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospitaf: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No : After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident filled in by the Director 6 ☐ Could not be 3 ☐ Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funerel Dire 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 in Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D21464 west, us 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3508 Bulto, pul 2/224 Robert LIBERTS Ms. Bank ST 31. Date filed (Month, Day, Year) 32. egistrar's Signature State APR 1 2 2006 Registrar

ORIGINAL

ham

			For State Registrar	State of	Maryland /		artment of H			Hygier	2006	Management of the second of th	09	
3	21		Decedent's Name (First, Middle, L	ast)			-		2. Date Mont	of Death		3. Time o	of Death	
	Physici /Medic		ANNIE BEI	L CLARK					Apr		,		55 p <sup>M</sup>	
	Examin		4a. Facility Name (If not institution, g	ive street and num	nber)		4b. City, Town, or	Location of	of Death		4c. County of [			
		a"	520 OAK AVEN				EDGEM		041100			MORE CO		
	Funeral			Sex 1 □ M 2XXF	7. Age (In yrs. last) 7. A	birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min. (Mon	h, Day, Ye	ar)	Birthplace (State Country)		
	Director		250-48-1057 Usual Residence of Decedent		74	113.			AUG	_10_1	931   5	OUTH CAR	COLINA	
	rland ow		10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside C	City Limits	
	Man I-f eh	to	MARYLAND BAI	TIMORE	EI	DGEMI	ERE					1 Tyes	2 XNO	
	r 288	Director	10e. Street and Number				10f. Zip Code			10g.	Citizen of Wha	Country?		
	ours after death with the Marylan ral', or iteme 23a or 28a-f ehow Examinar must be motified at		520 OAK AVEN	IUE			212	19			U.S.A.			
	eme eme	Funeral	11. Marital Status	12. Was Dece Armed For	dent Ever in U.S.	13.	Was Decedent of Hi f Yes, specify Cuba	spanic Ori n, Mexicar	gin? (Specify Yes n, Puerto Rican, et	or No- c.)		kmerican Indian, Vhite, etc.		
36	or it	by FL	1 Never Married 2 Married	If Yes, Give	8			Specify:			Specify:	BLACK		
Ö	72 hours after death with the Maryland Tretural, or Itema 23a or 28a-f ehow oltest Exeminational bandilled at	å D	3 ☐ Widowed 4 ☐ Divorced  15. Decedent's	Year or Da		6a Daca	dent's Usual Occupa	ation		16h	. Kind of Busin	es/Industry		
21215-0036	d within 72 ho jiana. r than "natur ina Medical	Completed	(Specify only highest s	rade completed)		(Give	kind of work done of DO NOT use retired	luring mos	t of working	100	. Turid or basiri	333 madstry		
212	within jiene. r than	E	Elementary/Secondary (0-12) 8th grade	College (1-		CULT	NARY ARTS				BETH ST	EET.		
פ	be filed stal Hygi of other event, I	BeC	17. Father's Name (First, Middle, La.	st)				18. Mothe	er's Name (First, M	iddle, Maid	len Sumame)			
<u> a</u>	should be ind Mental marked o umatic eve	일	GEORGE MIDDLETO	N				VICTORIA MOSELY						
Maryland	2 sho and is mu	<b>6.9</b>								lumber, Ci	y or Town, Sta	e, Zip Code)		
_	1 and 2 Health tem 27 i		Rev. Frank A. Cl	ark/Husb			Oak Ave.,	Balt	imore, M	7				
0	ges 1 a it of Hea if Item or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	☐Removal from S	0.000	etery, crer	sition (Name of natory or other place	e)	Date	20c	. Location - City	or Town, State		
Baltimore,	t. Pa rtmen rtent:		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		HOLL		LLS MEMOR	,		MID	DLE RIV	ER, MARY	LAND	
Bal	permit. Pages 1 a Depertment of He Important: if Item eny injury or othe		Ballana C	Brown	~	W	Name and Addres LLIAM C 206 W NO	BROWN	COMMUNI	TY FU	NERAL H	OME P.A.		
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that ca ly one cause on ea	aused the death. Dach line.	o not ent	er the mode of dying	g, such as	cardiac or respira	ory arrest,	Interval Be			
F	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Respiration queres to be to for as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying									Onset and	Death	
	/Medical Examiner		resulting in death)	Due to (c	or as a consequence	ce of):						6 m	enths	
	Examine:	ų.	Sequentially list conditions,	b. Me +	astatic	250	phageal	can	· C+					
	led Isit	nine	rf any, leading to immediate cause. Enter Underlying Cause (Disease or injury	D00 10 (c	or as a consequent	Ce OI).								
	al-trar	Examin	that initiated events resulting in death) Last	c. Due to (d	or as a consequenc	ce of):						-		
8760,	requires that the death certificate be executed been signed by the attending physician and hould be detached for use as the burial-transit	dicai		d										
9	ifficat g phy as th	0										4		
Вох	eath certific attending p for use as	N/OR	IF FEMALE: 23b. Was decedent pregnant		come of pregnancy		Ectopic pregnancy				23d. Date of		N.	
	s deat he att ed for	Physician/M	in the past 12 months?		ant at time of death		Other (specify)			_	Month	Day	Year	
P.O.	that the de led by the a detached t	Phy	9 Unknown			- '- M	-4	an in Dani I	220	Did tobas	o uso sontábu	e to the cause of	doeth?	
	res the signed be det	δ Δ	Part II. Other significant conditions	contributing to de	ath but not resulting	g in the ui	nderlying cause give	en in Parti	. 230.	1 ☐ Yes	-	Probably 4		
Ö	w requir been si should I	eted										546154		
3ec	G 2 C/	Completed							24a.	Was an autopsy performed	2 1000	autopsy findings to completion of	cause of	
a	en: The t tificete ha tor, page	e Co	or the one element a modical						1 🗆	Yes 2	No 1 □	Yes 2 No		
⋚	sici cer rec	00	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital:	npatient 2 ER/	Outpatier	t 3 DOA Othe		of Death (Check ursing Home 5	-	€ □Othor (	Engaful		
of		n: To	27. Manner of Death			b. Time of					njury occurred	эрвсиу)		
ion	Attending F ir death. ector: After by the funera	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat		n, Day Fear)	Injury		Yes 2□	No					
Division of Vital Records,	I or Atte after des Directo I in by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	⇒ 28a. Place	of Injury - At home, ng, etc. (Specify)	, farm, str	eet, factory, office		28f. Loca City	tion (Street or Town, St	and Number o	r Rural Route Nur	nber.	
	itel or rai Dir lled in								23/22					
	To the Hospitel or At within 24 hours after of To the Funeral Direct completely filled in by	ledical	29a. Certifier 1 Certifying (Check only one)	hysician: To the aminer: On the ba and mann	sis of examination	dge, deatl and/or in	n occurred at the tim vestigation, in my of	ne, date an pinion, dea	nd place, and due to the occurred at the	o the causi time, date	e(s) and manne and place, and	r as stated. due to the cause(	(s)	
	To the Ho within 24 h To the Ful completely	ž	29b. Signature and title of certifier	2			29c. License					lonth, Day, Year)		
	d		1/1/1/	mitte.	rsphysi	16190	200	608	76	4	18/06			
10	, 0		30. Name and address of p son wh	o completed cause	e of death (Item 23	a) (Type,	Print)		21	a -	/.b	40		
	Sta	205	Adam Pinstrer  31. Date filed (Month, Day, Year)	MP 910	i Fran	4/1-	1 de	0-	# 205	DQ	more,	213	5 1	
	Registr		ΔPR 1 9	2008	lacus &	X A	sq-un							

his certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - transit Division of Vital Records, P.O. Box 68760, To the Funeral Director: After the completely filled in by the funeral

Medical Certification: To Be Completed by Physician/Medical Examiner

events resulting in death) Last	Due to (or as a consequence c.  Due to (or as a consequence d.					
UNPENDED	AMENDED					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of pro  1 Live birth 4 Pregnant at time of  wn g Unknown	2 Fetal dea			ate of delivery onth Day	Year
Part II. Other significant condition	s contributing to death but no	t resulting in the underly	ing cause given in Part I.	23e. Did tobacco use of 1  Yes 2  No		e of death?
				24a Was an 2 autopsy performed? 1 ✓ Yes 2 No	24b. Were autopsy fin prior to completion death? 1 ✓ Yes	
25. Was case referred to medical			26. Place of Death (Chec	k only one)		
examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatient 2	✓ ER/Outpatient 3	DOA Other Nurs	ing Home 5 Residence	6 Other	
27. Manner of Death  1 Natural 5 Pending 2 Accident Investig		28b. Time of Injury 20:03	28c. Injury at Work? 1 Yes 2 ✓ No	28d. Describe how injury or Deceased passenge collision		ved in
3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place of Injury - At	home, farm, street, facto	ory, office building, etc.	28f. Location (Street and N or Town, State) Walther Ave & White		
one) 2 Medical Examil	ician: To the best of my knowler:On the basis of examination and manner stated	_				s)
20b Signature and title of centier			9c. License number	20d Date	signed (Month Day	Vearl

10d. Inside City Limits

1 XYes 2 No

Approximate Interval

Between Onset and

Death

31 Date filed (Month, Day, Year) State APR 1 2 Registrar

Susan Hogan MD.

of person who completed cause of death (Item 23a)

Assistant Medical Examiner



O.C.M.E.

April 7, 2006

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** James Gregory Coles April 7, 2006 2:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner GBMC @ Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Director 577-70-0434 Feb. 7, 1952 Michigan Usual Residence of Decedent 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits 7 is marked other than "natural", or itema 23a or 28a-f ehow traumatic avent, the Madical Examinar must be notified at 1 Yes 2 No Director Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 719 Woodbridge Center Way 21040 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 □ No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bfack, White, etc. 1 Never Married 25 Married 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Manager Electronic Retailer land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Health and Mental George Washington Coles Elizabeth (nmn) Hendricks Marvi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i 719 Woodbridge Center Way, Edgewood, MD 21040 of Disposition (Name of Date 2° c. Location City or Town, State Cendonia E. Coles / Wife Itimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H importent: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State Crownsville VA Cem. 4-11-06 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature 2 Funeral Service Licensee McComas Funeral Home, P.A. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) Colon cancer metastatic **Physician** montres /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Completed by Physician/Medical Box 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 ☐ Unknown o 9 Unknown α. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, sign be 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? res 2 (vo 1 ☐ Yes 2 ☐ No 1☐ Yes Vital director. 25. Was case referred to medical examiner? Be 26. Pface of Death Check only one Dthen: 4 Nursing Home 5 Residence 6 Other (Specify) NOJ PIC 1 ☐ Yes 2 🔀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဥ ō 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deat To the Funeral Diractor: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) yd ni belli filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58303 APRIL 7 2006

Registrar

State

0.

6601 N. Charles ST

32. Registrar's Signature

BALTIMORE MOZIZO4

30. Name and address of person who compfeted cause of death (ftem 23a) (Type, Print)

2006

AMON CUMMUES, US

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician Month 1403 M Apri Dorothy A. DeRemigis 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State Sept. 16, 1934 Maryland 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F 71 Yrs. 212-30-5867 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits an "natural", or itema 23a or 28a-f ahow Medical Examinar must be nutified at 1 ☐ Yes 2 ☑ No Director Md. Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21015 1306 Streamview Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 9 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be s 1 and 2 should be fit f Health and Mental H item 27 is marked of Mary Kuta John Pupek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1306 Streamview Court, Bel Air, Md. 21015 Antoinette Mercer/daughter permit. Pages 1 and Department of Healtl Important: If Itam 27 any injury or other tonce. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Gardens of Faith Cem. 4/12/2006 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 23a. Part 1. Enter the disease, or completitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximately 10.14 Ap Approximate
Interval Between
Onset and Death
2 Drys. Immediate Cause (Final **Physician** ACUTE PERITONITIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner PERIRECTAL ABSCESS. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by PULMONARY EDEMA 1 Yes 2 No 3 Probably 4 Unknown RENAL FAILURE CHRONIC 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? ARTERY CORONARY 1 ☐ Yes 2 ☐ No DISEMSE 1 Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one Hospital: 1 Impatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☐ NO 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Medical Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tyes 2 No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospitel or Attending Director within 24 hours a
To the Funerel C

#800H30583

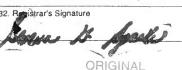
1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) C. VELLA- CAMILLERI M.D. 31. Date filed (Month, Day, Year) Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

32. Reistrar's Signature



1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 0021207

5 MIDCREST CT.

29d. Date signed (Month, Day, Year)

2006

21286

APRIL IOTH

BALTMORE MY

			1 - For State Registrar	State of Maryland	/ Department of Health and Certificate of Death	d Mental Hygien	ZIIII6 IIII13
	Physici		1. Decedent's Name (First, Middle, L. SON CEE ARA	y D	AVEN PORT	2. Date of Death Month D	ay Year
	/Medio Examir		4a. Facility Name (If not institution, gi	ve street and number)	4b. City, Town, or Location of Do	Path 4	c County of Death
	Funeral Director			Sex 7. Age (In trs. last	t birthday) If Under 1 Year If Under 24 H Yrs. Months Days Hours N	Irs. 8. Date of Birth fin. Month Day, Yea	9. Birthplace (State or Foreign Country)
	ס		Usual Residence of Decedent  10a. State 10b. County	10c. City, T	own or Location	0-25-5	10d. Inside City Limits
	he Maryl	Director	MD	B	eltimore		1 Yes 2 No
	23a or 2		10e. Street and Number	de Court	10f. Zip Code 21221	10g. C	Citizen of What Country?
9800	72 hours after death with the Maryland naturel; or Itema 23a or 28a-1 ehow disel Evantinar must be recitified at	d by Funeral	11. Marital Status  Never Married 2☐ Married 3☐ Widowed 4☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt  1 ☐ Yes No Specify:	(Specify Yes or No- lerto Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0036	be filed within 72 hours after death with the Marylan Ital Hygiene. od other than "naturel", or itema 23a or 28a-f ehow event. The Medical Evandrar must be routified at	Completed	15. Decedent's E (Specify only highest gi Elementary/Secondary (0-12)	2 Policing (1-4 or 5+)	6a. Decedent's Usual Occupation (Give kind of work done during most of the DO NOT use retired)	working 16b.	Kind of Business/Industry
Maryland	should be fill nd Mental H in marked oth	To Be	17. Father's Name (First, Middle, Las John Tins less 1 19a. Informant's Name/Relatis ship	DEVENDORT	18. Mother's t  Ger  19b. Mailing Address (Street and Number or	Name (First, Middle, Maide Fuele Ui Rural Route Number, City	Lliams
_	1 end 2 Health a em 27 le ther tree			emport		Slud, But	ocation · City or Town, State
Baltimore	Pa men mort: ury		Burial 2 Cremation 3 4 Donation 5 Other (Speci	Removal from State	etery, crematory or other place)	115/06 B	elto MD
Bal	permit. Departimports any nj		21. Signature of Funeral Service Lice	Insee Sura	P2 Name and Address of Figure 1	Load, Bal	to MD UZIZ
,	Physician /Medical		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	pplications that caused the death. If one cause on each line.  a	DIAL INFARCT	liác or respiratory arrest,	Approximate Interval Between Onset and Death 7 HRS
×	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Of Over to (or as a consequent		LEROSIS	YESTIS
8760,	cate be executed ohysicien and the burial-transit	dicai	that initiated events resulting in death) Last	c Due to (or as a consequent	ce of):		
P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2  No 9  Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de. 4 ☐ Pregnant at time of death 9☐ Unknown	ath 3 ☐Ectopic pregnancy		23d. Date of delivery Month Day Year
ords, P.	equires that ten signed by ould be deta	þ	Part II. Other significant conditions	contributing to death but not resulting	g in the underlying cause given in Part I.	1	use contribute to the cause of death?
al Reco	n: The taw r ficate has be nr. page 2 sh	Completed	SMOKEY			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
Division of Vital Records,	T - 6	Certification; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigatio	28a. Date of Injury (Month, Day Year)	Oth	9 Home 5 Residence 28d. Describe how inju	
DİXİ	To the Hospitel or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	Certific	3 Suicide 6 Could not b		, farm, street, factory, office	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, e)
	To the Hospitel within 24 hours a To the Funeral completely filled	edicai	29a. Certifier 1 Certifying Pt (Check only one) 1 Medical Example 1	nysician: To the best of my knowled miner: On the basis of examination and manner stated.	dge, death occurred at the time, date and pla and/or investigation, in my opinion, death oc	ce, and due to the cause(s curred at the time, date an	s) and manner as stated. d place, and due to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	Masan M	29c. License number  S0173H	1	ate signed (Month, Day, Year)
_	8		30. Name and address of pers in who	MINN MD, 90	000 FRANKLIN SQ DE	2, BALTIME	RIL 6,2006 ONE, MD 21237
	Sta Registra		31. Date filed (Month, Day, Year)  APR 1 2 2	32. Registrar's Signature	Local De la Contraction de la	,	,
DH	MH 17 Rev 1/20	01			-		

ORIGINAL

			i iodoc	State of Marylan	d / Department of H	lealth and Me		Legible.	
			1 - For State Registrar	Otate of Marylan	Certificate of		Reg. No	11116	Particular and Partic
	<b>3</b> 2. ₩.	7	Decedent's Name (First, Middle, La	ist)			2. Date of Death Month Da		3. Time of Death
	Physici /Medic		Lawrence (		vis SR.		4 4	2006	16.320M
	Examin	er	4a. Facility Name (If not institution, give	1 1 1 .		r Location of Death		. County of Death	
(3)	Funoral			Sex 7. Age (In yrs. 1		Hunder 24 Hrs.	8. Date of Birth	9. Birth	place (State or Foreign
	<ul> <li>Funeral</li> <li>Director</li> </ul>	(	216-54-5911	12 M 2□F 56	Yrs. Months Days	Hours Min.	(Month, Day Year)	O M	intry)
	and *		Usual Residence of Decedent  10a. State 10b. County	10c, City	r, Town or Location				10d. Inside City Limits
	Maryli f eho	tor	MD	B	altimore	l l			1 Xres 2 □ No
	death with the Maryland ime 23a or 28a-f ehow richan be collined at	Director	10e. Street and Number		10f. Zip Code		10g. Cit	tizen of What Cou	intry?
	ath wil	ralD	1813 Northb	ourne Road		1239		ISA	
	after de	Funeral	*11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent Ever in U. Armed Forces?	S. 13. Was Decedent of H If Yes, specify Cub.	lispanic Origin? (Spec an, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - Amer Black, White	
5-0036	hours aft	by	3 Widowed 4 Divorced	1 ☐ Yes 25 No If Yes, Give Year or Dates:	1 ☐ Yes No	Specify:		Specify: B	lack
2-0	72	Completed	15. Decedent's E (Specify only highest gr		16a. Decedent's Usual Occup (Give kind of work done	during most of workin	g 16b. K	(ind of Business/I	ndustry
121	within ene. then "	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)	life, DO NOT use retire	+00	$C_{\ell}$	ou str	uction 2
d 2	Hygie other	ပို	17. Father's Name (First, Middle, Last			18. Mother's Name	(First, Middle, Maiden	Sumame)	40,740
land	Mental Mental rked c	ToB	Robert Day	is		Flora	Egal	estor	ے د
lary	s 1 and 2 should be filed if Health and Mental Hyg item 27 le marked othe other traumatic event,		19a, Informant's Name/Relationship	Type, Print	19b. Mailing Address (Street	100	0	or Town, State, Zi	p Code)
e, Z	1 and dealth om 27 ther to		20a. Method of Disposition	219 Laughter	11918 Heat1	ntiedar	d, 13010	ocation - City or T	21239
nor	0 0 = 5		1 Burial 2 Cremation 3 E	Removal from State	emetery, crematory or other pla	2016 11/1	0/06 82	14 2 00	a MD
Baltimore	permit. Pag Department Important: any Injury c	H	21. Signature of Funeral Service Lice	1 1111	82. Name and Addre	ss of Facility	estures	71 L SO.	-Uims
ä	permit Depar Impor any In		I len W.	Sue	4905	UONK B	el. Bald	6 MID	21212
4 30 10			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not enter the mode of dyir	g such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	· Seps	5				Criser and Death
	Examiner		1	Due to (or as a consequ	dence of):	form of	Expec	CHANGE	2010 . 0
	4.43	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	uence of):	ory a	istress	Synon	· · · ·
X	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	· Upper		utestine	al Ele	ed	
,092	ite be ex ysicien a ne burial	cal E)	Toolsting in doubly East	Due to (or s f consequ	dence of P				
687	e ys			d					
Вох	death certifica e attending ph id for use as th	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal		,		23d. Date of deliv	
B	at the deat by the att tached for	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of de				Month	Day Year
P.O.	that the	Phy	Part II. Other significant conditions	contributing to death but not resu	ulting in the underlying cause given	en in Part I.	23e. Did tobacco	use contribute to	the cause of death?
ds,	9 <u>10</u> 9	d by	Alcaholic	, ,	disease		1 ☐ Yes 2		
Ö	law requii as been s 2 should	Completed	Altered	wental	Status		24a. Was an		opsy findings available
R		Com	PAULTER	titis			autopsy performed? 1 ☐ Yes 2 X No	death?	ompletion of cause of
/ita	oician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Heavitel		26. Place of Death	(Check only one)		
of	w =	-: To	1 ☐ Yes 2 No 27. Manner of Death		ER/Outpatient 3□ DOA 28c. Injur		ie 5 🗆 Residence 8d. Describe how inju		fy)
ion	nding Phy ath. r: After thi e funeral	atlor	Natural 5 Pending Accident investigation	28a. Date of Injury (Month, Day Year) n	Injury Wor	k? Yes 2 □ No		,	
Division of Vital Records,	l or Attendate death Director:	Certification:	3 Suicide 6 Could not be determined		me, farm, street, factory, office	2	8f. Location (Street ar City or Town, State		al Route Number,
Ω	To the Hospital or Attenwihin 24 hours after deatl To the Funeral Director:		00. 0.4%						
	24 hos	edical	29a. Certifier 1 ➤ Certifying Pl (Check only one) 2 ☐ Medical Exa	hysician: To the best of my knorminer: On the basis of examination and manner stated.	wiedge, death occurred at the til tion and/or investigation, in my c	ne, date and place, a pinion, death occurre	nd due to the cause(s d at the time, date and	) and manner as: d place, and due	stated. to the cause(s)
	within To the	Me	29b. Signature and title of certifier		29c. Licens			te signed (Month	
)	10		Dmitr: Se	our dalnitsk	, MD R	es ode	9	1410	6
	3		30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)	2100.01	120 Pald	(5 <sub>4.1.</sub>	111 2/226
	Sta	te	31 Data filed (Month Day Year)	32 Penietrar's Signal	tura	weype	va, with	more,	NO 21239
	Registi		APR 1 2 200	6 Kenya St	Sperter				

DHMH 17 Rev 1/2001

lawrence, bruis

			1 - For State Registrar	State	of Marylar		artment of H		and Mental Hy	/giene Reg. Ng. () (	16	and the second s
	Physici	-	Decedent's Name (First, Middle		N BAYNE	DENTO	NT.		2. Date of D Month April	Day	Year 006	3. Time of Death
1	/Medic Examin		4a. Facility Name (If not institution			DENTO	4b. City, Town, or	Location o			ty of Death	6:00 a <sup>M</sup>
6. 1			Pickersgill Re	tirement	Communi	ty	Т	owson		Ba1	timore	e County
	Funeral		5. Social Security Number	6. Sex 1 ☐ M <b>2/CX</b> F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 2 Hours	Min. (Month, D	irth ay, Year)	9. Birthp	place (State or Foreign
	Director		216-03-0466 Usual Residence of Decedent		9	1 Yrs.			June	21,1914		MD
	land ow		10a. State 10b. County		10c. Ci	ity, Town or Lo	ocation				1	IOd. Inside City Limits
	Mary 1-f sh	tor	MD Bal	timore		Towson						1 ☐ Yes 2000No
	ier death with the Marylan Items 23c or 28a-f show rec must be notified at	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	23E		615 Chestn					2120	•		USA	
	er der Items	Funeral	11. Marital Status	12. Was De Armed I	cedent Ever in U Forces? : 2 🔼 No	J.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Orig In, Mexican	7in? (Specify Yes or N , Puerto Rican, etc.)	lo- 14. Ra Bla	ace - Americ ack, White,	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorced	If Vac C	Bive		1 ☐ Yes 2 🛣 No	Specify:		Spec	₩hite	е
21215-0036	be filed within 72 hours after death with the Maryland Hygiene.  ad either than "natural", or items 23s or 28a-f show arent, The Medical Evant ser must be neithed at a veent, the Medical Evant ser must be neithed at	ted		it's Education	4)	16a. Dece	dent's Usual Occup	ation	at wanting	16b. Kind of I	Business/In	dustry
218	within 7 ene. than "n	Completed	(Specify only highe Elementary/Secondary (0-12)		(1-4or 5+)	life.	kind of work done of DO NOT use retired	during most	or working			
2	filed with Hygiene. other than	Con	12	1			Secret		4 44 5000 4 400 4 11		rt Cle	erk
and	l be fi	Be	17. Father's Name (First, Middle,		Darmo				r's Name <i>(First, Middle</i> orence Sim		(me)	
Maryland	d 2 should be the and Mental I is markad o traumatic ave	ဥ	19a. Informant's Name/Relations	James E.	Daylle	19b. Maili	na Address (Street a		r or Rural Route Numi		n. State. Zic	Code)
			Lawrence M. De		Son	4.1			MD 21654	, , ,		,
Je,	Lawrence M. Denton — Son  1.0. Box 37, Oxford, MD 21654  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)  20b. Place of Disposition (Name of cemetery, crematory or other place)											own, State
Ē	Pages nent of ant: If it ary or o		1-  Burial 2  Cremation    4  Donation 5  Other (S		II State		Memorial		4/12/06	Parkvi	11e, N	<b>1</b> D
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service	Licensee	eld Funera	Funeral Home, Inc.						
ш	20E # 9	100	- Joan V. 11	Mehlu		6.	500 York	Road,	Baltimore	, MD 21:		
	Physician /Medical		23a. Part. Enter the disease, or concept, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on	each line.	e Ve	unc :	SAI	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Examiner			Due to	O (or as a consec	quence or):	astro a	2nt	eritis			week
		ner	Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
	sate be executed shysician and the burial-transit	Examiner	that initiated events	C								
50,	oe execian a		resulting in death) Last	Due to	o (or as a consec	quence of):						
8760,	physicate by the control of the cont	dica		d								7.4
Вох 6	eath certific attending p	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o	utcome of pregn	ancy				23d. D	ate of delive	erv
B.	death d for i	iciar	in the past 12 months?	4☐Pre	birth 2∏Feta gnant at time of c		<pre>]Ectopic pregnancy</pre> ] Other (specify)				fonth	Day Year
P.0	at the de by the a tached	hys	9 Unknown	9∐ Unk	nown							
	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	Part II. Other significant conditi				refu		1	tobacco use coi Yes 2 No	ntribute to th 3 ☐ Prob	ne cause of death?
of Vital Records,	an: The law re tificate has be tor, page 2 shu	ompleted	ling dise	ase w.	16	COR	pulma	nnle	auto	s an 24b opsy formed? 22 No	were auto prior to con death? 1 \( \sum \text{Yes}	psy findings available mpletion of cause of
/ita	sician: T certificat rector, pa	BeC	25. Was case referred to medica examiner?					26. Place	of Death (Check only	one)		
of V	Physician: this certific ral director,	은	1 ☐ Yes 2 XNo		Inpatient 2		-	- Court	rsing Home 5 Res			y)
	ling F	lon:	27. Manner of Death  1 Natural 5 □ Pendir	ng (Mo	e of Injury onth, Day Year)	28b. Time o Injury	Worl	yat k? Yes 2.⊟1		how injury occu	irred	
Division	Attanding or death. actor: After by the fune	ficat	2 Accident investi 3 Suicide 6 Could	not be	ce of Injury - At h	nome, farm, sti	reet, factory, office	163 2 1		(Street and Nun	nber or Rura	al Route Number,
Ο̈́	after Dira	Certification:	4 Homicide determ	buil	ding, etc. (Speci	ify)			City or To	own, State)		
	To the Hospital or Attanding I within 24 hours after death. To the Funeral Diractor: After completely filled in by the funer	edical C	29a. Certifier (Check only one)	Examiner: On the	ne best of my kn basis of examina inner stated.	owledge, deat ation and/or in	h occurred at the tin vestigation, in my o	ne, date and pinion, deat	d place, and due to the h occurred at the time	e cause(s) and n , date and place	nanner as st , and due to	tated. o the cause(s)
	To th withir To th comp	~	29b. Signature and title of c. rtifie	er .	10		29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
			Il that	may 1	uly	, cuo	02	520	2_	Apri	110	2006
3	1		30. Name and address of person	who completed ca	use of death liter	т 23а) (Туре,	Print)	1/2.	lo St	Roll	4 12	12 212
			31. Date filed (Month, Day, Year,	124 G	Popularia Sim	6/0	11/4-6	a Cal	10001	500	0, 10	
	Sta Registr	20	ADD 1		Registrar's Sign	B A	aste					

lygiene	$\cap$	n	100	1

	1 - For State Registrar	State o	f Mar	yland / De <i>C</i>	epartme <i>Certifica</i>				lental Hy	gien Reg. N	2111	16	
	1. Decedent's Name (First, Middle, Last)								2. Date of De	ath			3. Time of Death
n	Mathilda Augusta	Draver							April 7	200	ay	Year	10:08 P M
al er	4a. Facility Name (If not institution, give s		n <i>ber)</i>		4b. City	, Town, or	Location	of Death	1 1 1 1 1	1	c. County	of Deat	
	Gilchrist Center				Tows	son				]	Baltin	ore	
	Social Security Number     6. Sex		7. Age (	In yrs. last birtho	fay) If Under	or 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th Vea	(1)	9. Birt	hplace (State or Foreign untry)
	219 30 9583	M 2□F X	77	Yrs	s. Months	Days	Hours	WIII.	May 23	1928	"	Balt	imore CO., MD
	Usuel Residence of Decedent												
٠.	10a. State 10b. County			0c. City, Town o									10d. Inside City Limits 1 ☐ Yes 27 No
Scto	Maryland Baltimore			Baltimore									
<u>=</u>	10e. Street and Number					ip Code				-	Citizen of \	What Co	untry?
2	6136 Ebenezer Road					L220					USA.		
n Pe		<ol> <li>Was Dece Armed Fo</li> </ol>	rces?	er in U.S.	<ol> <li>Was Dec</li> <li>If Yes, sp</li> </ol>	edent of Hi edify Cuba	ispanic Or n, Mexicai	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	)-		e - Ame ck, White	rican Indian, e, etc.
Z >	1 Never Married 2 Married	1 ☐ Yes If Yes, Gi	/0		1 🗆 Yes	2 <b>□X</b> No	Specify:				Specify	v: T.b	ite
ο Ο	3 XWidowed 4 □ Divorced	Year or D	ates:	10- 5		.1.0				1.01	16' - 1 - 1 B		
ē	15. Decedent's Edu (Specify only highest grade	completed)		(C	ecedent's Usi Give kind of w fe. DO NOT	ork done o	ation du <i>ring</i> mos	t of work	ing	160.	Kind of B	usiness/	industry
Completed by Funeral Director	Elementary/Secondary (0-12)	College (			Employe	_	,			F	lorist		
Š	17. Father's Name (First, Middle, Last)	T.V.	. 1	) SELL	піртоує		18. Moth	er's Nam	e (First, Middle				
) Be	August Koch								Gress			-,	
0	19a. Informant's Name/Relationship (Ty	ne Printl		10h M	lailing Addres	s (Street			al Route Numb	er Cit	or Town	State 3	7in Code)
	Deborah C Drayer	,/			•				e, Maryla			J-410, Z	
	20a. Method of Disposition			20b. Place of D	isposition (Na	me of	I.		Date			City or	Town, State
	1 DBurial 2 ☐ Cremation 3 ☐ R	emoval from	State		crematory or			10.0	~~			•	
	4 Donation 5 Other (Specify)			Holly Hi			-		шь	Barr	timore	, Mar	yland
	21. Signature of Funeral Service License	" <u></u>	~	0	Lassahr				c				
	MICHION ASS	0	The		7401 B	lair l	Poor! P	altim	or respiratory	Jan	1 2123	36	
	23a. Part1. Enter the dis se, or compli shock, or heart failure. List only or	cations that one	ach line.	e death. Lo not	enter the mo	de of dyin	g, such as	cardiac	or respiratory	rrest,			Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	Br	uin	Cancer									Years
	resulting in death)	Due to	(or as a	consequence of)	:								
	Sequentially list conditions.												
<u>=</u>	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury	Due to	(or as a r	tonsaquence of)	9								
E	that initiated events resulting in death) Last												
Ω	1650king in death, East	Due to	(orasa o	consequence of).	:								
edical Examiner												-	
	IF FEMALE:												
au	23b. Was decedent pregnant in the past 12 months?	3c. If yes, ou 1∐Live t		pregnancy Fetal death	3 □Ectopic	pregnancy					23d. Da	te of del	ivery Day Year
S	1 ☐ Yes 2 🙀 No	4□Pregr 9□Unkn		ne of death	5 Other (s	specify)					1410	,,,,,,,	Day
Completed by Physician/M	9 Unknown								00 - Did				the second death 2
2	Part II. Other significant conditions con	inbuting to a	eath but	not resulting in tr	ne underlying	cause give	en in Part	l.					the cause of death?
E G									1	Y 0 S	2 🗆 No	3 🗆 Pr	obably 4 Donknown
<u>pe</u>									24a. Was		1	prior to o	topsy findings available completion of cause of
ē									perfe	ormed?		death?	<b>^</b>
De C	25. Was case referred to medical						26. Place	e of Deat	h (Check only				
0	examiner? 1 ☐ Yes 2 No	ospital:	Inpatient	2 🗆 ER/Outpa	atient 3 0	Oth	er: 4 🗆 N	ursing Ho	me 5 Res	dence	e Doth	er (Spe	city) Hospice
<u>.</u>	27. Manner of Death	28a. Date	of Injury	(ear) 28b. Tim	ne of	28c. Injun Worl		-	28d. Describe	_			, ~
atic	1 Natural 5 Pending 2 Accident investigation	(,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, way 1	, ""	М		Yes 2□	No					
2	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		of Injury	· At home, farm	, street, facto	ry, office			28f. Location (			er or Ru	ıral Route Number,
Ce.	. Chomoso	Duild	ing, otc.	(Specify)					City of 10	.v., 516			
Medical Certification;	29a. Certifier 1 Contifying Physical (Check only one)	ician: To the ner: On the b and man	asis of e	xamination and/o	laath occuma or investigatio	d at the time on, in my o	13, data al pinion, dea	nd place, ath occur	and due to the red at the time,	causal date a	(s) and ma nd place,	armar as and due	stated. to the cause(s)
Σ	29b. Signature and title of certifier				2	9c. License	e number			29d. D	ate signe	d (Monti	h, Day, Year)
	Jana Her	s m	0			D00	611	99					2004
	30. Name and address of person who co	mpleted caus	se of dea	th (Item 23a) (Ty	(pe, Print)	c C	<i>†</i>	7	- /	61	71	20	4
	unson Marie	0007	10	0117 6	narle	7 9	2 1	045	Du V	-11)	1	10	1

State Registrar

31. Date filed (Month, Day, Year)

APR 1 2 2006

Examine

**Funeral** Director

permit. Pages 1 and 2 should be tiled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-1 show any injury or other traumatic avent, the Modical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.

To the Funeral Director: After this certificete has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

34 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #20b Per FH G856 6/02/96/1/jpgate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** APRIL 852 A M COLEY DILLARD 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs. BALTIMORE NORTHWES 7 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 220-64-9884 M 2□F Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heelth and Mental Hygiene. Intel 17 is marked other then "natural", or Itams 23a or 28s-1 ehow 10d. Inside City Limits 10a. State Item 27 is marked other then "natural", or Itams 23a or 28s-1 show other traumatic event, the Micdical Examinar must be notified at 1 Yes 2 No Funeral Director timore 10g. Citizen of What Country? 10e Street and Man 10f. Zip Code 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 14. Race -11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify. Completed by Diac 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Ov (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle. Father's Name (First, Middle, Last) Be Department of Heelth a Important: If Item 27 Is eny injury or other trat once. 240MU 20a. Method of Disposition

1 Burial 2 Cremation 20c. Location - City or Town, State 3 Removal from State 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Servi 8728Liberty 16town 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician hours disease or condition resulting in death) hepatorenel arlune /Medical Due to (or as a consequence of): Examiner alcoholic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physicien and for use as the burial-transit hours Cardiopulmona

Due to (or as a consequence of): that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day signed by the at the detached for 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should b 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No hes autopsy performed certificate 2 X No 2)( No 1 Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification; 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funeral Dire 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 00059736 MO n

Registrar DHMH 17 Rev 1/2001

State

NORTHWEST

ITO SPITAL

5400

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD.

32. Registrar's Signature

WATSON

DEBORAT

31. Date filed (Month, Day, Year)

			1 - For State Registrar	State of Marylar		nt of Health and l	Mental Hygien	CUUh	
			Decedent's Name (First, Middle, Las	t)			2. Date of Death		3. Time of Death
	Physici	an	Jesse	,	EANR	<	Month D	ay Year	5'454 M
	/Medic		4a. Facility Name (If not institution, give	street and number)		, Town, or Location of Deat	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	c. County of Death	5. 7517
	Examin	er	BALT MORE VA	Medical C	entel P	ALHMORE		NA	
			5. Social Security Number 6. Se			or 1 Year If Under 24 Hrs	8. Date of Birth	9. Birthi	place (State or Foreign
	Funeral Director			M 2DF Q/	Yrs. Months		Month, Day, Year	2 VCou	ntry)
			Usual Residence of Decedent		0		1010	J   V 11	9111100
	land		10a. State 10b. County	10c. Ci	ty, Town or Location				Tod. Inside City Limits
	Man	to	MD	1 1	So 1 time	200			1 res 2 No
	28a	rec	10e. Street and Number		10f. Z	ip Code	10g. C	itizen of What Cou	ntry?
	death with the Maryland ms 23a or 28a-f show rimust be rediffed at	Funeral Director	1427 N. 1 in	1000 Aug	1110	21213		1154	
	me 2	era	11, Marital Status	12. Was Decedent Ever in U	.S. 13. Was Dec	edent of Hispanic Origin? (Secify Cuban, Mexican, Puer	specify Yes or No-	14. Race - Ameri	
	riter	ᆵ	1 Never Married Married	Armed Forces?  1 Yes 2 □ No If Yes, Give			to rican, etc.)	Black, White,	etc.
3	hours after tural', or tte	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 □ Yes	No Specify:		Specify: 13/	2CK
2-003p	be filed within 72 hours after death with the Marylan it all typiene. It all typiene. It all the marker is a standard to the them with the marker above swant. It is Marker is a marker in the marker is a standard to the marker in the marker is a standard to the marker in the marker is a standard to the marker in the marker is a standard to the marker in the marker is a standard to the marker in the marker is a standard to the marker in the marker is a standard to the marker in the marker is a standard to the marker is a standard to the marker is a standard to the marker in the marker is a standard to the marker	Completed	15. Decedent's Ed		16a. Decedent's Us	ual Occupation ork done during most of wo	rking 16b.	Kind of Business/Ir	dustry
<u> </u>	hin 7	pie	(Specify only highest gra	Coilege (1-4or 5+)	life. DO NOT	use retired)		11 01	. 1
N	filed within 72 Hygiene. Ither than "na! ant, it a wadie	No.	140		Steel	- Worke	e 154	SH SH	eel.
<u> </u>	e file	Be (	17. Father's Name (First, Middle, Last)			18. Mother's Na	me (First, Middle, Maide	n Surname)	
<u>a</u>	ould be d Menta narksd natic so	0	James T. Fa	NPS_		Juli	A Kan	dall	
a Z	d 2 should th and Men 7 is marks traumatic		19a. Informant's Name/Relationship (1	Type, Print)	19b. Mailing Addres	ss (Street and Number or Ri	ural Route Number, City	or Town, State, Zij	Code)
Ma	alth alth		Mary O. Eas	jes/Wite	1427 N	LINDOOD	Ave, Ba	1 to MI	21213
<u>o</u>	other		20a. Method of Disposition		Place of Disposition (National Competers), crematory or	ame of other place)		ocation - City or T	own, State
IIII	Pages nent of int: If it iry or o		Burial 2 Cremation 3 4 Donation 5 Other (Specify		MISONI TON	est constent	13/06	ICIGS M	Ile MA
=	First and		21. Signature of Funeral Service Licen	see O	Name a	and Address of Facility	18 of Truses	7 R 500	1:000
g	Pering Pering Sany		Mauden C.	Downel	450	5 by r		10 Mil	11212
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the dea	th. Do not enter the mo	de of dyin, such as cardia	c or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final	_	Psis				Onset and Death
	/Medical		disease or condition resulting in death)	a Due to (or as a consec					
	Examiner		1	13	moniA	_			
		ē	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	b. Due to (or as a consec					
	uted d ansit	声	Cause (Disease or injury that initiated events	_					
,	exec n and ial-tra	Examiner	resulting in death) Last	Due to (or as a consec	quence of):				
9	law requires that the death certificate be executed as been signed by the attending physicien and a should be detached for use as the burial-transit	cail		d					
89	ficat g phy ss the								
ROX	eath certific attending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn				23d. Date of deliv	ery
ň	death atte	C.	in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth 2☐Feta 4☐Pregnant at time of c				Month	Day Year
o.	at the de by the a tached	ysi	9 Unknown	9□ Unknown					
7	uires that signed b d be deta	y P	Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying	cause given in Part I.	23e. Did tobacco	use contribute to	he cause of death?
Records,	uires sigr	d by	MYOCARdi	AL INFA	RCTION	,	1 ☐ Yes	2 <b>□ N</b> o 3 □ Pro	bably 4 Dunknown
<u></u>	w requir been si should	Completed	/	1			24a. Was an	24b. Were auto	opsy findings available
ě	The law cate has page 2	Ę.					autopsy performed?	prior to co	impletion of cause of
	an: The tificate tor, pa		Or Manager uniform day and disch				1 ☐ Yes 2 ☐ N	lo 1 Yes	2□ No
Z Z	Physician: T r this certificat ral director, pi	Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:		Other	ath Check only one	. =	
ō	Phys rat d	. To	1 Yes 2 Alo		ER/Outpatient 3 [	A Nulsing I	lome 5 ☐ Residence 28d. Describe how in		fy)
ב	ding P. After funer	ion	1 ☐Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Injury	28c. injury at Work? 1 ☐ Yes 2 ☐ No	234. 0000.00 11011 119	a.y 500054	
Division	r Attendi ter death. Irector: A Ire to the fu	ica	3 Suicide 6 Could not be				28f. Location (Street	and Number or Rur	al Route Number
≥	or At effer of Direct in by	Certification:	4 Homicide determined	building, etc. (Speci	fy)	, onice	City or Town, Sta		a. r. obio romodi,
	To the Hospital or Attending within 24 hours efter death.  To the Funeral Director: After completely filled in by the fune		29a. Certifier 1 Certifying Ph	ysician: To the best of my kn	owledge, death occurre	d at the time, date and place	e, and due to the cause!	s) and manner as	stated.
	# Hos 24 h	Medical		niner: On the basis of examination and manner stated.					
	To the within ?	Me	29b. Signature and title of certifier		2	9c. License number	29d. D	ate signed (Month,	Day, Year)
	⊬ ≱ ⊬ ö		1 1 1	/: us		Placai	4		-
	1		mus yar	ali MD	- 020 \ (Tr   2010)	118286	F	pril /	2000
	1		30. Name and address of person who	completed cause of death (Ite AND HI	m 23a) (Type, Print) [/]	P18586 Nichi Gree	12 6 16 . L	ROLLING	e. MA DINA
			31. Date filed (Month, Day, Year)	B2. Registrar's Sign	ature 🗸	INVERT UKEE	NUSTREAT	W71-71/10	اللواح الماء
	Sta								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Foster 40 M nomas J. Hon 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner NIA University of Maryland Medical Certer ff Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) ff Under 1 Year 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 212.46.593 1 M 2□ F Days Hours MD Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. fnside City Limits \*Phow rei', or items 23s or 28a-f ehov Examiner must be notified at NIA MD Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 Road Whith LISA Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: if item 27 ie marked other than any injury or other traumatic. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Marned 1 Yes 2 No Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 13a Himore nspector 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Abraham Coleman toster trances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5631 Whitby Road Baltimore MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 04.11.06 Baitimone MD rarden of Faith 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility nd Address of Facility In C. Breene Euneral Services York Road Batto, MD 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** POXIA a respiratory /Medical Examiner SAVAMOVS 10 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts. Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetaf death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page this certificate 2□ No 1 ☐ Yes 2 → No 1 Tyes After this certification, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf. 1 Denpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 3 ☐ Süicide 6 Could not be determined 28e. Pface of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

APR 1 2 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Greene

Baltimore

			1 lease	Obstant Man						•	ione	oic.	
			For State	State of Mar	yland		rtment of t				7 1111	6	11421
			Registrer  1. Decedent's Name (First, Middle, Las	st)		001	incate or	Death		Date of Dea			3. Time of Death
	Physicia /Medic		1011221 F	ar/94					A	Month	Day Ev	o L	5:58 AM
ž.	Examin		4a. Facility Name (If not institution, give	1 . 1			4b. City, Town,	or Location of	of Death	-/+	4c. County		
			5. Social Security Number 6. S	1015,186	(In use Is	st birthday)	If Under 1 Year		24 Hrs. 10	Date of Birth		Zifn.	Diace (State or Foreign
	Funeral Director			<sup>1</sup> M 2√√ 38	iii yis. ie	Yrs.	Months Days		Min. Au	(Month, Day	14°,1967	Nev	Jersey
	D .		Usual Residence of Decedent		io- Cir.	, Town or Loc							
	anyla	ō	10a. State 10b. County  Maryland Carroll	'		ersbur							10d. Inside City Limits
	28a-f	rect	Maryland   Carroll  10e. Street and Number		LIU	ei spai	10f. Zip Code			1	10g. Citizen of V	Vhat Cou	
	th with	Funeral Directo	6158 Osage Ct				217	784			US	SA	
	teme	uner	11. Marital Status	12. Was Decedent Ev Armed Forces?		5. 13. W	/as Decedent of Yes, specify Cul	Hispanic Ori oan, Mexicar	igin? (Specify n, Puerto Ric	Yes or No- an, etc.)	14. Raci Blac	e - Ameri k, White,	can Indian, etc.
36	rs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2\7\No If Yes, Give Year or Dates:		1	□ Yes 🗶 🕽 No	Specify:			Specify	: V	Mhite
1215-0036	be filed within 72 hours after death with the Maryland nat lygiene. Id other then "natural", or iteme 23a or 28a-f ehow event, the Medical Examinar mina to inciting a sevent.	ted	15. Decedent's Ed	ducation		16a. Deced	ent's Usual Occu	pation	et of working		16b. Kind of Bu	ısiness/In	dustry
2	ithin 7	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)		life. D	O NOT use retin	ed)	a or working				
2	filed w Hygier other th		17. Father's Name (First, Middle, Last)	4			Market		er's Name (F	irst. Middle.	Ut 1 Maiden Sumam	iliti	es
Maryland	should be filed within of Mental Hygiene. marked other then imatic event, the Mental Control of the Mental con	To Be	Michael Donald Lar						othea				
ary	s 1 and 2 should t Health and Men item 27 le marke other traumatic		19a. Informant's Name/Relationship (				g Address (Stree						Code)
	s 1 and 3 if Health item 27 other tr		J. Christopher Far	riey H	US		Osage Ct	Erde	rsburg	-	y I d II U Z 20c. Location -		own State
Baltimore,	Peges 1 nent of h int: If ite iry or ot		20a. Method of Disposition  XX Burial 2 □ Cremation 3 □	Removal from State	Ce	metery, crem	atory or other pla						
	permit. Peges Department of Importent: If it eny injury or o		4 □ Donation 5 □ Other (Specifical Licer		Durai		ey Mem Ga Name and Addi				Timonium, defeld Fu		
ä	Deg E e		Xennis Stesh	en Xenas	Ex								aryland 21212
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	ne death	. Do not ente	er the mode of dy	ing, such as	cardiac or re	spiratory arr	rest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Lorric	al	(64	cer 4	: 76	me	Back	SVIS_		Criset and Death
	/Medical Examiner		rossining in dodiny	Due to (or as a	consequ	ence of):							
	*-	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	consequ	ence of):							
	nd nd transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c									
760,	ate be executed hysicien and he burial-transit	cal Ex	resulting in death) Last	Due to (or as a	consequ	ence of):							
687	ficate physics the		•	d									
Box (	h certi	W/U	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2			Ectopic pregnan	~v				e of deliv	,
	The law requires that the death certifica ste has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4☐Pregnant at til			Other (specify)				Mo	nth	Day Year
P.0	hat the	Phy	Part II. Other significant conditions of	contributing to death but	not resu	Iting in the un	deriving cause o	ven in Part I	ı. İ	23e. Did to	bacco use conti	ribute to t	he cause of death?
Vital Records,	uires u signe	d by								1 🗆 Y	es 2 No	3 Prol	bably 4 Unknown
S	s beer s shou	Completed								24a. Was a	an 24b. \	Were auto	ppsy findings available
ž	The la	Com								autop: perfor 1 Yes	med?	death?	ompletion of cause of 2□ No
/ita	Attending Physicien: Thir death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				~	e of Death (C	heck only or	ne)		
o	Physic this ral dir	. To	1 Yes 2 No 27. Manner of Death	28a. Date of Injury		ER/Outpatient 28b. Time of	3 □ DOA □ 28c. Inj				lence 6 Oth		fy)
on	nding th. :: Afte	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury	l W	ork? ]Yes 2∐			. ,		
Division of	er des rector	Certification:	3 Suicide 6 Could not b	e 28e. Place of Injur- building, etc.	y - At ho	me, farm, stre	eet, factory, office		28f	Location (S City or Tow		er or Run	al Route Number,
	e Hospital or Attending 24 hours after death. • Funaral Director: After etely filled in by the funer		Continue of Continue Di	National Table has at			4.4			d	(-)		
	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funaral Director: After this certificate ha completely filled in by the funeral director, page	edicai		nysicien: To the best of miner: On the basis of e and manner state	xaminat								
	To the within 2 To the complet	Me	29b. Signature and title of certifier				29c. Licer	se number		1	29d. Date signed	d (Month,	Day, Year)
	h d		Alila 1	15, 1			1-1	439	74		April 1	6, 2	006
	2		30. Name and address of person who	completed cause of dea	ath (Item	23a) (Type, I	Print)		, ,	1 -		-	meiyland
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar	's Signat	ture /	1 (05)	1/3/	- teg	ndy	IND WA	,	neight of
	Regist		APR 1 2 2	2006 Brews	1	ture	EASIL!						

			For State Registrar	State of	Marylan		artment <i>tificate</i>			and M	lental Hy	giene Reg. No.	1106	11422
			1. Decedent's Name (First, Middle, L	ast)							2. Date of De Month	ath Day	Year	3. Time of Death
	Physici /Medic		Dorothy				Fulbri	lght			April :		006	11:40 A <sup>M</sup>
60	Examin		4a. Facility Name (If not institution, g	ive street and nun	nber)		4b. City, T	own, or	Location of	of Death		4c.	County of Dea	th
			Shady Grove Adve				Rock			0411			ontgome	
	* Funeral		,	Sex 1□M 2XF	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Months		If Under Hours	Min.	8. Date of Bird (Month, Da July 12	th y, Year) 1 0 2	9. Bir Co	thplace (State or Foreign buntry) Texas
	Director		466-60-7129 Usual Residence of Decedent		70						July 12	2,193	))	Texas
	filed within 72 hours after death with the Maryland Hygiene. ther than "neturel", or lame 23a or 28a-f ehow int, the Macinal Examinar must be natified at		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	be filed within 72 hours after death with the Marylan stat hygiene. Id other than "neturel", or Itame 23e or 28e-1 ehow event, the Macical Examiner must be natified at	호	MD Montgor	nerv	Ga	ithers	ourg							1 A Yes 2 No
	h the	Director	10e. Street and Number				10f. Zip (	Code				10g. Citiz	zen of What Co	ountry?
	th wil	ai	504 Palm Tree Di	cive			2	.087	8			US	SA	
	dea ame	Funeral	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.	Was Decede	nt of Hi	spanic Ori	gin? (Spe	ecify Yes or No Rican, etc.)	- 1	14. Race - Ame Black, Whit	
9	or It	교	1 Never Married 2 Married	1 ☐ Yes If Yes, Give	2 🔯 No e	1	⊺ Yes 21		Specify:	,			Specify: B	_
ğ	ure!',	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Da	ites:									
ÿ	"net	ete	15. Decedent's (Specify only highest g	Education rade completed)		16a. Deced	ient's Usual kind of work DO NOT use	Occupa done d	ation fu <i>ring</i> mosi	t of work	ing	16b. Kir	nd of Business	/industry -
2	withir ane. than	Completed	Elementary/Secondary (0-12)	College (1-	-4or 5+)	_	orer	remed	/			Ins	urance	
N	Hygid ther ther	ပ္	17. Father's Name (First, Middle, Las	st)		Dat	0101		18. Mothe	r's Name	(First, Middle)	Maiden	Sumame)	
Maryland 21215-0036	d d d	o Be	Bill Fluckus	•							wson			
2	2 should be and Menta Is marked eumatic ev	2	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	a Address /	Street a			Il Route Numbe	er. City or	Town. State.	Zin Code)
æ ≥	C a =		Vivian Brock/Dau								Gaither	-		20878
	tand Health tam 27 other tr	1	20a. Method of Disposition	bucci	20b. F	Place of Dispo	sition (Name	g of	Ţ		Date		cation - City or	Town, State
<u>و</u>	Pages nent of ent: If it ury or o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		state	emetery, crer estlawi	-		9)	4-1	5-06	Par	is, Te	xas
altimore,		1	21. Signature of Funeral Service Lic		100				s of Facilit		xey Fur			
ä	permit. Departi Imports eny inj		2 Jennis	Vill	21811 W						, Paris			5460
			23a. Part1. Enter the disease, or co	mplications that ca	used the deat									Approximate
	Physician		shock, or heart failure. List on Immediate Cause (Final	ly one cause on ea	ich iine.	100	2101	1 5 7	() a	2 1 > /				Interval Between Onset and Death
}	/Medical		disease or condition resulting in death)	a. Due to (	or as a conseq	uence of):	DION	40	PAI	4				
	Examiner			. Aox	271C	STE	JO51	Z		•				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a conseq	uence of):								-
	outed td ranslt	Examiner	Cause (Diseese or injury that initiated events	c.										
ĵ	e be executed sicien and e burial-transit	Ex	resulting in death) Last	Due to (d	or as a conseq	uence of):						_		
8/60	ate hy	lical		d		<del></del>								
Õ ×	eath certific attending pl	Mec	IF FEMALE:	20. 1/										
X R R	death co	ian/	23b. Was decedent pregnant in the past 12 months?		rth 2 ☐ Feta	Ideath 3	Ectopic pre					2	3d. Date of de Month	livery Day Year
_ ;	0 0	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregna 9☐ Unkno	ant all time of d wn	eath 5∟	Other (spe	cify)						,
J.	that the ed by th detache		Part II. Other significant conditions	contributing to de	ath but not res	ulting in the u	nderlying car	use give	en in Part I		23e, Did to	obacco u	se contribute to	the cause of death?
Vital Hecords,	iaw requires tha es been signed I 2 should be det	d by	DIABETES V	ELLM	15		- 1-11-				10	Yes 2	□No 3□P	robably 4 Kunknown
င္ပ	w requir been si should	lete	HYDERTENS	1.01							24a. Was	20	24h Were a	ulopsy findings available
ě	sicien: The law s certilicete hes t lirector, page 2 s	Completed	11 PERILAS	100							autop perfo	rmed?	prior to death?	completion of cause of
<u>a</u>	iticete or, pa		25. Was case referred to medical						OF Plans	of Dooth	1 ☐ Yes	2 No	1 🗆 Yes	2 □ No
	sicia s cert lirect	To Be	examiner?	Hospital: 1 VIII	patient 2 🗆	ER/Outpatien	t 3 DOA	Othe			me 5 ☐ Resid		Other (See	
Ö	Attending Physician: r death. ector: After this certitio by the funeral director,		27. Manner of Death	28a. Date o	f Injury	28b. Time of		c. Injury Work			28d. Describe I			City)
<u></u>	nding F uth. r: After e funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigati		n, Day Year)	Injury	м		<br Yes 2 🔲 I	No				
Division	Attending ar death. ector: After by the funer	ifica	3 ☐ Suicide 6 ☐ Could not determine	d 286. Place	of Injury - At he	ome, farm, str	eet, factory,	office			28f. Location (S			ural Route Number,
5	s afte	Certification;	TIOMING.	Dandin	rg, etc. (Opecii	<i>y</i> /					Chy of You	vii, State)		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier 1 Cartifying F	Physician: To the aminar: On the ba and mann	sis of examina	wledge, death tion and/or in	occurred avestigation, i	t the tim	e, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s) date and	and manner as place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and mann	J. 314100.		29c.	License	number			29d. Date	e signed (Mont	h, Day, Year)
	⊬ ≯ ⊢ ŏ		North Dans				T	17	110					
•			30. Name and address of Jerson wh	o completed cause	of death (Item	n 23a) /Type	Print)	-12-	110	-			10912	
		1	30. Name and address of Jerson wh	CE 1 141		125 S <sub>1</sub>	100	GO	alc.	R	Rock	1111	E MA	2006 Chaypa
	Sta	te	31. Date filed (Month, Day, Year)	32. Pd	gistrar's Signa	ature t	11011	~1F	<u>~\t-</u>	11)	1	-,	-1 43	104111
	Registr		APR 1 2 2	2006	San J	de d	self)							

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar		State of	Marylan		artmen rtificate			and M	ental Hy	giene Reg. No	11116		23
	Physici	an	1. Decedent's Name Peggy		Last) Fried							2. Date of Dea Month		y 2006	3. Time o	of Death
	/Medic Examir		4a. Facility Name (If r			ber)	-	4b. Citv.	Town, or	Location o		April		County of Death	7	J / WI
	LXaiiiii	iei	· · · · · · · · · · · · · · · · · · ·		ursing H					more						
	Funeral		5. Social Security Nur		i. Sex 7	. Age (In yrs.		If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Day	h v, Year)	9. Birth	place (State	or Foreign
	Director		213-20-		70 W 261	86	Yrs.					Sept.	10,	1919 V	irgi	nia
	yland how		10a. State	10b. County			y, Town or Lo								Od. Inside (	City Limits
	Ba-fs	ctor		Balti	more	Е	dgeme	re							1 🙀 Ye:	s 2 🗌 No
	with th	Funeral Director	10e. Street and Numb		Avenue			10f. Zip		1.0			10g. Cit	tizen of What Coul	ntry?	
	ns 23	eral	11. Marital Status	ermar	12. Was Deced	ent Ever in U	S. 13. V		212 Jent of Hi		pin? (Spe	cify Yes or No-	. 1	USA 14. Race - Americ	an Indian,	
9	after or iter	Fun	1 Never Married	d 2 ☐ Marrie	Armed Ford	es? X No		fYes, <i>s</i> peo 1 □ Yes :2			, Puerto I	cify Yes or No- Rican, etc.)		Black, White,		
003	72 hours after death with the Maryland "natural", or items 23a or 28a-f show offical Examiner must be notified at	d by	3 ☑ Widowed 4		Year or Dat	es:								Specify: Whit		
21215-0036	⊆ =	Completed	(Specify	, ,	grade completed)		16a. Deced (Give life, I	dent's Usua kind of wol DO NOT us	il Occupa rk done d se retired,	ation <i>luring most</i> )	of worki	ng	16b. K	ind of Business/In	dustry	
212	filed within Hygiene. Ither than "	mo	Elementary/Second	dary (0-12)	College (1-4 4	for 5+)	Offi						E	ducatio	n	
nd	d fall	Be	17. Father's Name (F		ast)							(First, Middle,	Maiden	Surname)		
Maryland	Men Men srke	2	Henry C		(Toron Orion)		40) 44 7	0.67.	(0)	Anna			0:			
Ma	12 sh ar h ar 7 is trau		Peggy A.			ughte	1	17 B	,					re, Md.	- /	16
re,	f Health item 27 other tr		20a. Method of Dispo	sition		20b. P	lace of Dispo emetery, cren	sition (Nan	ne of	1		ate		ocation - City or To		30
mo	Pages nent of i		1 □ Burial 2 🛣 1 □ Donation 5		☐Removal from St cify)	are !	-				ri1	6, 20	006	Baltim	ore,	Md
Baltimore,	permit. Page Department Important: Il any injury o		21. Signatore of Fund	eral Service Li	eensee		22 B	Name an	d Addres ey-A	s of Facility Ashto	213 on F	4 Will uneral	low L H	Spring	Rđ.	2122
			23a. Part1. Enter the shock, or heart	disease, or co	omplications that cau	alta Linno									Approxima Interval Be	tween
2	Physician		Immediate Cause (Fi disease or condition resulting in death)	inal	_ a/	Ther	usel	croll	c	Hea	nt	Prsea	se		Onset and	Death
B	/Medical Examiner		rooming in south,	- 1	Due to (or	as a consequence	uence of):	02236	-			Deseà				
ļ		ner	Sequentially list conditions, leading to inni- cause. Enter Underly Cause (Disease or in	ditions, nediate	b. Due to (or	as a conseq										
V	acuted and transi	Examine	Cause (Disease or in that initiated events resulting in death) La		c											
8760,	ate be executed hysician and the burial-transit		Todaling in doubly ca		Due to (or	r as a conseq	uence or):									
9	w ===	ledlc			d											
Вох	death certific e attending pl od for use as t	an/N	23b. Was decedent p in the past 12 m		23c. If yes, outco	me of pregna		Ectopic pro	egnancy					23d. Date of delive	,	Year
O. E	0 0	Physician/Medical	1 Yes 2 12 11 9 Unknown		4□Pregnar 9□Unknow	nt at time of do	eath 5□	Other (sp	ecify)					MOHUI	Day	1041
٦,	de ag	by Ph	Part II. Other signific	ant condition	s contributing to dea	th but not res	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	bacco	use contribute to the	ne cause of	death?
rds	w requires been signe should be		12pe	21/	abeles ?	nda	tus					1 🗆 Y	'θ <i>s</i> 2	IVNo 3 □ Prob	ably 4 🗆	Unknown
Vital Records,	aw as b	ompleted	Dem	entra								24a. Was a autop	SV	24b. Were auto	psy findings mpletion of	available cause of
al H		O										1 ☐ Yes	med2 2 ☑ No	death?	2 No	
Z.	Physician: This certificate all director, p	o Be	25. Was case referred examiner?	•	Hospital:	patient 2	ER/Outpatien	t 3□ DO	Othe	r /	-	(Check only or		6 □Other (Specif	v)	
υot		T :uc	27. Manner of Death	5 Pending	28a. Date of		28b. Time of Injury		8c. Injury Work	at		8d. Describe h			//	
siol	Attending r death. ector: After by the fune	catle	2 Accident	investigat	t he			М		res 2□N						
Division	Dir	Certification:	4 Homicide	determine	ad 280. Place o	f Injury - At ho p, etc. (Specify	me, tarm, str	eet, factory	, office		2	City or Tow		nd Number or Rura n)	u Houte Nur	nber,
	of the Second	edical (	29a. Certifier 1 (Check only 2 one) 2	☑ Certifying ☐ Medical Ex	Physician: To the bas aminer: On the bas and manne											s)
)	To the P within 24 To the F complete	Me	29b. Signature and tit	tle of certifie	net ,	-, (	lung	290	License	number .	56	2	29d. Da	te signed (Month,	Day, Year)	
	2		30. Name and address	/\ A	onnes, M	of death (Item	23a) (Type,	Print)	uood	AUG	BA	ACTO,	mg	212	24	
	Sta Registr	-	31. Date filed (Month,	PR 1 2	2006	gistrar's Signa	The Asia	Solal		·				te signed (Month,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 9:04 H M 1006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 7AHMORE chis If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min 218-64-1152 Usual Residence of Decedent 1**X**M 2□ F Yrs. Director Apri Pages 1 and 2 should be fited within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other then "natural", or iteme 23s or 28e-f ehovent, the Medical Examiner must be notified at Maryland 1 Yes 2 No Directo more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be and Mental ျှ amue ieno 19a. Informant's Name/Relationship (Type, Print) Brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health Ito. item 2 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State important: l eny injury o once. 4/13/2006 4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel 22. Name and Address of Facility 21. Signature of Funeral Service Licenses oh L. Russ Fuperal W. North Ave. Balto 23a. Pany Enter the disease, or complications that eaus shock, or heart fallure. List only one cause on each Approximate Interval Between Onset and Death exised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Cerebellar Hemorrhage **Physician** days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine rsician and a burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medicai attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed 2 No 1 Tyes 2□ No 1 ☐ Yes or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 (Natural 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funerei Dire the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: Un the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1285-000 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frad S. Sutton 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 1 2 2006 Registrar

			1 - Stat Amend Items#2	State of Marylan 20b&c per FH G8	d / Depa 54 4/1	artment of H	ealth and Death	Mental Hyg	giene Reg. No.	006	1425
			1. Decedent's Name (First, Middle, L.	^				2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic		Thearis	Gree	n			April	_6	200	6 10:41AM
	Examin		4a. Facility Name (If not institution, gi	1 1 / 1		4b. City, Town, or	11 1		4c. 0	County of Dea	th
				ospital Cent		Kanda	listow				
H	Funeral Director			Sex 7. Age (In yrs. 1 M 2/F 58	Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi		v, Year)	9. Bir	thplace (State or Foreign ountry)  NC
	land		10a. State 10b. County	10c. Cit	y, Town or Lo	ocation					10d. Inside City Limits
	Mary -1 sh	tor	MD Balti	more	Randa	llstown					1 □ Yes X□ No
	hours after death with the Maryland tural', or Itema 23a or 28e-f show al Examiner must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citiz	en of What Co	ountry?
	th wit	aiD	3523 Cornstrea	am Road		2	1133			U.S.	A •
	ems ems	Iner	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? n. Mexican, Pu	(Specify Yes or No-	1	4. Race - Ame Black, Whit	
õ	or it		1 Never Married 2 Married	1 ☐ Yes 2 💢 No If Yes, Give		1 ☐ Yes 2X No	Specify:				
2-003p	ural',	d by	3 ☐ Widowed 4 🛣 Divorced	Year or Dates:	162 David	d				· · · E	Black
Ç	n 72	iete	15. Decedent's E (Specify only highest g	-ducation rade completed)	(Give	dent's Usual Occupa kind of work done d DO NOT use retired.	furing most of w	vorking	16b. Kin	d of Business	Vindustry
7	J within 72 hours after death with the Marylan jiene, then *natural; or Items 23a or 28e-f show Ite Medical Examiner must be notified at	Completed	Efementary/Secondary (0-12)	Colfege (1-4or 5+) <b>na</b>		ctory W				Facto	ry
5	E T S T	Be C	17. Father's Name (First, Middle, Las	t)	!		18. Mother's N	lame (First, Middle,	Maiden S	Sumame)	
la la	ild be lental rked c	To B	Frank Koonce				Lucill	e Ander	son		
a	shor and N man	_	19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	ng Address (Street a	and Number or	Rural Route Numbe	r, City or	Town, State,	Zip Code) 21208
Σ	alth a		Tanya Shaw-Dau	ıghter	24 St	ockmill	Road	Apt B,	Pike	svill	.e, Md
e e	of He		20a. Method of Disposition		emetery cree	osition (Name of matory or other place	θ)	Date		ation - City or	
altimor	Pag ment ant: I ury o		Burial 2 Cremation 3 Contact C	ify)	ng Men	orial Par	k Park	4/12/0	Randa	11sto	Mđ
ğ	permit. Pages 1 end 2 should be Department of Health and Menia Important: If Item 27 Is marked any Injury or other traumatic ev <u>once</u> .		21. Signature of Funeral Service Lice		M č	Name and Addres	s of Facility.				
מ	20559		/ Providuo (	1. Yugut	43	300 Waba	sh Ave	, Balti		e, Md	21215
			23a. Part1. Enter the disease, or cor shock, or heart failure. List ont	nplications that caused the death y one cause on each line.	h. Do not ent	er the mode of dying	g, such as card	ac or respiratory an	rest,		Approximate Interval Between Onset and Death
j	Physician		Immediate Cause (Final disease or condition resulting in death)	a Right midd	le cer	ebral a	rtery	infarction	on		Crisci and Boat.
	/Medical Examiner	L	resulting in death)	Due to (or as a conseq	uence of):	1.	- (				
		L.	Sequentially list conditions,	b. CEVEDYD VA		r dise	ase				
	ted nsit	nine	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	Dao to (or as a conseq	donos or).						
	axecu and al-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):						
2/20	certricate be executed ding physicien and ise as the burial-transit	cal		d							
Q	fficat g phy as the										
ŏ	andin use	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. ff yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy			2:	3d. Date of de	livery
מ	death te etter	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at time of d		Other (specify)				Month	Day Year
Э	et the	Physician/Med	9 Unknown								
	law requires thet the death certifical as been signed by the ettending pt 2 should be detached for use as t	ρ	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause give	en in Part I.		1	/	o the cause of death?
ecords,	equir sen s	Completed	Hypertension					- 1 Y	′es 2 🗓	5No 3∐P	robably 4 Unknown
ပ္	e 25 C1	ple						24a. Was autop	sy .	prior to	utopsy findings available completion of cause of
r =	The cate h	Con							20 No	death? 1 ☐ Yes	s 2□ No
VITAI	ysician: The lav is certificate has director, page 2	Be	25. Was case referred to medical examiner?	Hospitaf:		04-		eath (Check only o	ne)		
	Phys this al dir	. To	1 Yes 2 No 27. Manyer of Death	28a. Date of Injury	ER/Outpatier 28b. Time o		4   140151119	Home 5 Resid			ecify)
	ding h. After funer	tion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Work	rat (? Yes 2 □ No	200. Describe ii	iow inquiy	occurred	
DIVISION	Attending Physician: r death. sctor: After this certific by the funeral director.	fical	3 Suicide 6 Could not	be 390 Blace of Injury At he	ome, farm, str			28f. Location (S	Street and	Number or R	ural Route Number,
2	after Dira Jin b	Certification;	4 Homicide determine	building, etc. (Specif	y)	out, radiory, direct		City or Tow			
	To the Hospital or Attending Physwithin 24 hours after death.  To the Funstal Director: After this completely filled in by the funeral di	ai C	29a. Certifier 1 Certifying P	hysician: To the best of my kno	wledge, deat	h occurred at the tim	ne, date and pla	ice, and due to the	cause(s) a	and manner a	s stated.
	in 24 he Fu he Fu	edicai	(Check only 2 Medical Exa	miner: On the basis of examina and manner stated.	uon and/or in	vestigation, in my op	oinion, death oc	curred at the time, o	date and	piace, and du	e to the cause(s)
	To t Withi To tl	Ž	29b. Signature and title of certifier	M D		29c. License			29d. Date	signed (Mon	th, Dey, Year)
•	/		J Boston	VID.		NYS	1462		AP	1116	2006
	5		30. Name and address of person who	1 ( )	2. 1	1	Carta	- D i	11.4		A / 1
			J Boston M.  31. Date filed (Month, Day, Year)	D Northwe	· · · · ·	tospital	Center	r Rando	VIISIO	wn 1	naryland
	Sta Registr		APR 1 9 200	M . Ha	084	as of the same					

	-	For State Registrar		State o	f Maryla	and / Depa	artmen rtificat					giene Reg. No.	06	11426
		1. Decedent's Name (First,	Middle, L	ast)							2. Date of Dea	ath Day	Year	3. Time of Death
Physicia /Medica		Mary			Emma		G	ibbs	3		April	6	2006	0120 AM
Examine		4a. Facility Name (If not inst	tution, g	ive street and nu	mber)				Location	of Death		4c. Cc	ounty of Death	n
		Union Mem					Bal							
Funeral Director		5. Social Security Number 219-30-679(		Sex 1 M X F		3 Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da 08 1.	y. Year) 3 32	9. Birti Coi	nplace (State or Foreign untry) MD
bug ≱_	-	Usual Residence of Decede  10a, State 10b, Co			10c.	City, Town or Lo	ocation							10d. Inside City Limits
/aryli	៦	MD	NA			Baltim	ore							1X Yes 2 □ No
iG after death with the Maryland or Itema 23s or 28s-f show inher must be notified at	Funeral Director	10e. Street and Number			1		10f. Zip	Code				10g. Citizer	n of What Co	untry?
With With	ੂ	312 East 2	Oth	Stree	t.			212	18			Ţ	J.S.A.	
after death w	era	11. Marital Status		12. Was Dec	edent Ever in	n U.S. 13.	Was Deced	dent of H	ispanic Or	igin? (Sp	ecify Yes or No Rican, etc.)	- 14.	Race - Ame	
after or lite		1 Never Married 2	Married	Armed Fo 1 ☐ Yes If Yes, Gi			1 ⊡ Yes				nican, etc.)		Black, White	e, etc.
5-0036 72 hours after natural; or ite	2	3 Widowed 4 □ Div	orced	Year or D	ates:		103	ar no	эрвспу.			3,	B]	lack
21215-0036 Id within 72 hours aft giene. or than "natural", or than Medical Exercit.	Completed			Education rade completed)		(Give	dent's Usua kind of wo	rk done d	during mos	t of work	ing	16b. Kind	of Business/I	ndustry
within solution than	ē.	Elementary/Secondary (0		College (	1-4or 5+)		DO NOT us		)			D۳	ivate	
of filed within all Hygiene.	ဒ	11th grade  17. Father's Name (First, Mi		na		l D	omes	FIG	18 Math	er's Nam	e (First, Middle,			<b>-</b>
and lbe fi mtal H ed of	Be	10 TAX - TAX - TAX - TAX - TAX												
hould Me d Me mark	2	Harry Barr  19a. Informant's Name/Rela				19h Maili	na Address	(Street			Water:		own State Z	in Code)
IOCE, Maryland 21215-003 ges 1 and 2 should be filed within 72 hours t of Heath and Mental Hygiene. If item 27 is marked other than "natural; or other traumatic event, the Medical Eve	1					The second of								
Heal Heal	1	Charles Ba	rret	tt-Son	20	<ul> <li>Place of Dispo</li> </ul>	sition (Nan	ne of			altimo Date		tion - City or	1207 Town, State
nt of nt of r: If it		ty□ Burial 2 □ Crema				cemetery, cre					10 100			
Baltimore, permit. Pages 1 at Department of Hee Important: If item any injury or othe	1	* 4 ☐ Donation 5 ☐ Ott 21. Sonature of Funeral Se			! K						12/06_1	kanda	IIIsto	own, Md
Baltimo permit. Page Department of Important: If any injury or once.		Mum	<u></u>	RX	ele	M 4	Name and arch 300	F/Wab	H We ash	st Ave	, Balt	imore	e, Md	21215
		23a. Part1. Enter the disea. shock, or heart failure	se, or con List onl	mplications that on the control on t	aused the deach line.	eath. Do not en	ter the mod	e of dyin	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between
Physician		Immediate Cause (Final disease or condition		Puly	none		Em		lisr	n				Onset and Death
/Medical		resulting in death)	•	Due to		sequence of):	,		^					0
Examiner		Sequentially list conditions.	- 1	b. En	7 2	tage	LU	MO	1	an	cer			2 years
7 2 #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	Due to	(or as a cons	sequence of):		-						
3760, ate be executed hysician and he burial-transit	E	that initiated events resulting in death) Last	1	C. Due to	lor as a cons	sequence of):	_	_					_	
760, te be ex ysician ysician		•		<b>Dub</b> (0	(01 43 4 001)	saquones on.								
87 cate I	dical		•	d		·								
o.O. Box 68 If the death certifical by the attending phy tached for use as the	Completed by Physician/Med	IF FEMALE:		23c. If yes, ou	teome of nre	anancy						222	d. Date of deli	
Box Bath cert attendin for use	ia E	23b. Was decedent pregnating the past 12 months:		1☐Live	ointh 2 ☐ F	etal death 3	Ectopic pr					230	Month	Day Year
O shed bed	28	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9☐ Unkn		ndeam st	T On let (2b	ecity)				ļ		
F 5 5 6	2	Part II. Other significant co	nditions	contributing to d	eath but not	resulting in the u	nderlying c	ause give	en in Part I		23e. Did to	obacco use	contribute to	the cause of death?
sign sign	2										101	res 2 0	/ No 3∐Pro	obably 4 Unknown
of Vital Records,  Physician: The law requires t this certificate has been signe ral director, page 2 should be	ete					• • • • • •					24a. Was	an s	Ah Wara au	toney findings available
Pec le law has b	Ē.						·				autor	sy rmed2	prior to death?	topsy findings available completion of cause of
Vital Re											1 ☐ Yes	2 No	1 🗆 Yes	2 No
of Vita Physician: this certific	ng Re	25. Was case referred to m examiner?	edical	Hospital:				Othe	0.00		h (Check only o		70 (2	
Phys raidi	2	1 Yes 2 No 27. Manner of Death			•	2 ER/Outpatie		M	4 🗀 🕅	irsing H	ome 5 Resident			ery)
Afte fune	<u> </u>	1 12 Natural 5 □ P	ending vestigati		of Injury th, Day Year	) Injury	м	8c. Injun Worl	k? Yes 2 🔲	No				
Division or Attending after death. Director: After	200	3 ☐ Suicide 6 ☐ G	ould not	be 28e. Place	of Injury - A	it home, farm, st	reet, factory	, office		-			lumber or Ru	ral Route Number,
Div atter	Certification;	4 Homicide	BIBITIMA	build	ing, etc. (Spe	ecify)					City or Tov	vn, State)		
Hospital 14 hours a 15 Funeral (	<u>။</u> ၁၂	29a. Certifier	tilying f	Physician: To the	best of my	knowledge, deat	n occurred	at the tin	ie, date ar	id place,	and due to the	caust(s) an	d manner as	stated.
9 Hos 24 h Fur etely	edical	(Check only 2 Me	dical Ex	aminer: On the b	asis of exam ner stated.	ination and/or in	vestigation	, in my o	pinion, dea	th occur	red at the time,	date and pla	ace, and due	to the cause(s)
Divisit To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Š	29b. Signature and title of c	ertifier				290	. License	e number				igned (Month	n, Day, Year)
->=0		· // /	/ /	45	M.D.			DO	533	373	,	Apr	:16	2006
	i	30. Name and address of po	rson wh	o completed cau	se of death (	Item 23a) (Type.	Print)		-		1	,	1 -	
5		Paul Kang		201 Ea	st On	iversity	Park	way	13	alti	more, N	larylan	nd 2	1218
Stat	e	31. Date filed (Month, Day,	Year)	32. F	legistrar's Si	gnature	les .							
Registra		ADD 1 9	200	6 Along	20 83	- Aller								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 2 per Dr., G854, 04/12/06dhb Reg. No. 1 - For State Registrar 04/01/2006 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** resdou CUIN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Nursing Center Baltimor Under 1 Year | If Under: horien Frankford 2/206 Baltimore City If Under 24 Hirs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1X M 2□F Yrs. 29 215-88-8612 2/8/1977 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Exercitive must be notified at 1 Tyes 2 No Director Glen Burnie Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number death with 7833 Cheverly Lane 21060 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: within 72 hours after 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: white Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. Pool Tech Swimming Pools es 1 and 2 should be filed wi of Health and Mental Hygien fitem 27 Is markad other th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Galen Smith Mary Ann Fauver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Ronald Gresdow /StepFather 7883 Cheverly Lane; Glen Burnie, MD 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages I Department of H Important; If ite any injury or of 1 XBurial 2 Cremation 3 Removal from State Glen Haven Mem. Park 4/11/2006 4 □ Donation 5 □ Other (Specify) Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral Home, PA 21. Signature of Funeral Service Licensee Moi357 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) En caphalofolly ue to (or as a kinsequent of): Pnysician /Medical Due to (or as a Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ner certificate be executed burial-transi Exami and Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? ō 4 Pregnant at time of death 5 Other (specify) signed by the al 9 Unknown The law requires that the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Dunknown 1 ☐ Yes 2 ☐ No peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page 2 20 No 1 ☐ Yes 12 No 1 Yes 26. Place of Peath Check onl one in by the funeral director, Be Other: Fursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA ٩ this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident 24 hours after deat e Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide Hospital or pellil

P.O. Division of Vital Records.

> State Registrar

Medical

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

4 [4 [06

who completed cause of death (Item 23a) Type, Print)

filed (Month, Day, Year) 2006

29a. Certifier

31. Date

within 24 ho To the Fune

To the

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Harry James Gaffney 10, 2006 08:40 a.M April /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1802 Fallston Road Fallston Harford Co. If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □XM 2 □ F 64 216-36-0086 Yrs. 1941 Director 6, Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthen "natural", or Itema 23s or 28s-1 ebow the Madical Examinar must be notified at 1 ☐ Yes 2 ▼ No Director Maryland Harford Co. Fallston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1802 Fallston Road 21047 United States 12. Was Decedent Ever in U.S. Amed Forces?

1 ∑ Yes 2 □ No
If Yes, Give
Year or Dates: 1062 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1958-1 ☐ Yes 2 No Specify: Specify: ð White 3 Widowed 4 Divorced 1962 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) Forklift Manufacturing Salesman 12 yrs. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) nit. Pages 1 end 2 should be file bertment of Heelth and Mental Hi octant: If Item 27 Is marked oth Injury or other treumatic even Gaffney Catherine E. Kocher Harry Α. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Sharon A. Gaffney / Wife 1802 Fallston Road Fallston, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State permit. Page Depertment Important: If eny Injury or Hilltop Service Corp. 4/13/2006 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 5305 Harford Rd. 21. Signature of Fur ral Service Licensee 22. Name and Address of Facility Michael E. Canapp Baltimore, MD Leonard J. Ruck, Inc. 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each time. Approximate Interval Between Onset and D, an Immediate Cause (Final disease or condition resulting in death) ano Physician Marinoma /Medical Due to (or as a consequence Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use es the burial-translt Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð icete hes been sig r. page 2 should b take 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No After this certificate 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 Yes 2 No investigation 2 Accident Director: / Vitin 24 hours en...

To the Funeral Director 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2006 d address of person use of depath (Item 23a) (Type, Print) 30 Name and C 32 Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

2006

			Please Type or State o			i <mark>sure All Copies</mark> h and Mental Hy	_	111.20
			For State Registrar	Ce	rtificate of Dea	th	Reg. No.	11467
	sicia edic	n	1. Decedent's Name (First, Middle, Last)  Jo Elizabeth Harmel			2. Date of De Month April	Day 2006	3. Time of Death 12:45 P M
1000	mine		4a. Facility Name (If not institution, give street and nur 13029 Fork Road	nber)	4b. City, Town, or Locat  Baldwin	ion of Death	4c. County of Dea	imore
Fune Direc	_		5. Social Security Number 6. Sex 197-38-8018 1□ M 2以 F	7. Age (In yrs. last birthday, 58 Yrs.	If Under 1 Year   If Un   Months   Days   Hou	order 24 Hrs.  8. Date of Bin (Month, Da Sept.	9. Bir 13, 1947 F	thplace (State or Foreign puntry)
yland	4		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L				10d. Inside City Limits
the Ma		Director	Maryland Baltimore  100. Street and Number		Baldwin		10g. Citizen of What Co	1 ☐ Yes 2 No
ath with		ralDi	13029 Fork Road		2	1013	u.s.A.	
5-0036 72 hours after death with the Marylan natural, or items 23a or 28a-1 ehow		by Funeral	11. Marital Status  1	rces? 2 🏿 No re	Was Decedent of Hispanic If Yes, specify Cuban, Med 1 ☐ Yes 2 🂢 No Specify Cuban Specific No. 1 ☐ Yes 2 💢 No. 1 ☐ Yes 2 💢 No. 1 ☐ Yes 2 ☐		- 14. Race - Ame Black, Whit	
<del></del>		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (15+	(Give	edent's Usual Occupation e kind of work done during DO NOT use retired)	most of working	Self-Emplo Retail Sto	ryed
N got			17. Father's Name (First, Middle, Last)			lother's Name (First, Middle,		nce
		To Be	Joseph Baldovich				aham	
≥ 5 € 5 €	100	1	19a. Informant's Name/Relationship (Type, Print)  Lawrence R. Harmel (hu		ing Address (Street and Nu 29 Fork Rd.,	mber or Rural Route Number Baldwin, MD	er, City or Town, State, . 21013	Zip Code)
Baltimore, permit. Pages 1 ar Depertment of Hea Important: If Item	5		20a. Method of Disposition  1 ☐ Burial 2 🖄 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Bayview	osition (Name of matory or other place) Crematory		20c. Location - City or Baltimore,	Maryland
Ball permit Depending	Suc		21. Signature of Funeral Service Lidensee			acility Schimunek Rd., Baltimor		
Physici /Medic Examir	cal			ach line.	iter the mode of dying, such		rrest,	Approximate Interval Between Obseyand Death
68760, tilicate be executed g physician and as the burial transit	Š	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  c	or as a consequence of): or as a consequence of):				
Geath cer e attendir	es per loi pero	Physician/Medic	in the past 12 months?	ant at time of death 5	□Ectopic pregnancy □ Other (specify)		23d. Date of de Month	livery Day Year
- Z 2 9		<u>م</u>	Part II. Other significant conditions contributing to d	eath but not resulting in the u	underlying cause given in P	23e. Did to	obacco use contribute to	o the cause of death?
	haga k si k	Completed				24a. Was autor perio 1 □ Yes	ary 24b. Were at prior to death?	utopsy findings available completion of cause of
of Vital F Physician: Th this certificate		Be	25. Was case referred to medical examiner?		Othor	Place of Death (Check only o	nne)	
Of Phys	5	n: To	27. Manner of Death 28a. Date	npatient 2 ER/Outpatie of Injury 28b. Time of Injury Injury	ALL SUIDON 4E		dence 6 Other (Spe how injury occurred	icify)
Division of the state of the st	in Dy itle to	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place	of Injury - At home, farm, st ng, etc. (Specify)	M 1 Yes		Street and Number or R vn, State)	ural Route Number,
Div To the Hospital or visitin 24 hours after To the Funeral Dire	Delli kieje	Medicai Ce	29a. Certifier Certifying Physician: To the (Check out) 2 Medical Examiner: On the b and man	best of my knowledge, dea asis of examination and/or in per stated.	th occurred at the time, dat nvestigation, in my opinion,	e and place, and due to the death occurred at the time,	cause(s) and manner a date and place, and du	s stated. a to the cause(s)
To the within To the	duos	Me	29b. Signature and title of certifier	rlo for	29c. License numb	5814	29d. Date signed (Mohi	th, Day, Year)
·	b		30. Name and address of person who completed barn	e of death (tem 23a) (Type	OsbrDa	SUTTE 37	Flowso.	nmDzizo
Rec	Stat gistra		31. Date filed (Month, Day, Year)- 32. APR 1 2 2006	egistrar's Signature				
DHMH 17 Re	v 1/20	01	Jacob Jac	ORIGI	NAL			-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			For State Registrar	State of Maryl		irtment of Hea tificate of De		ntal Hygle		11430
	Dhusisi		1. Decedent's Name (First, Middle, La	, 11				Date of Death Month	Day Yea	3. Time of Death
	Physicia /Medic		MARGUERI		ber			PRIL C	2006	3'00 P M
	Examin	er	4a. Facility Name (If not institution, giv	RUXION		4b. City, Town, or Lo			4c. County of De	TI Mode
	Funeral		5. Social Security Number 6. S	ex 7. Age (In	yrs. last birthday)	If Under 1 Year If		Date of Birth (Month, Day, Y		irthplace (State or Foreign
	Director		219-50-6706	OM 200 9	3 Yrs.	Months Days	Hours Min.	A4 26	1912	MO
	and w		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits
	Maryl -f sho lied s	ţo	MD N	A	1	BALTIMON	Le			1 □Yes 2 □ No
	with the Maryland a or 28a-f show be notified at	Funeral Director	10e. Street and Number			10f, Zip Code		10g	. Citizen of What (	Country?
	ath will	ralD	3200 OAKC	rest Ave			1234		U.S.1	
	lteme	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever	in U.S. 13. V	Vas Decedent of Hispa Yes, specify Cuban, M	anic Origin? (Specify Mexican, Puerto Ric	y Yes or No- an, etc.)	Black, Wi	nerican Indian, nite, etc.
1215-0036	be filed within 72 hours after death with the Maryland tal Hygiene d other than "natural", or lteme 23a or 28a-f show event, the Micdical Examiner must be notified at	by	3 ₩idowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	□Yes 2□No S	Specify:		Specify: (	shite
2	72 ho natur	Completed by	15. Decedent's E (Specify only highest gro		(Give	lent's Usual Occupation kind of work done during	n ing most of working	16	b. Kind of Busines	s/Industry
121	within one. then	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	Tife. L	OONOT use retired)	AKER		Hone	
N D	filed w Hygie other t		17. Father's Name (First, Middle, Last				. Mother's Name (F	irst, Middle, Ma		o
<u></u>	Ald be Aental rked tic ev	To Be	ALBERT Mei	NSchein			Bertha	Mills	5	
Maryland 2	2 should land Men ls marke		19a. Informant's Name/Relationship (	No.		g Address (Street and	-			
	1 and 1ealth em 27 ther tr		MATILDA K  20a, Method of Disposition	(N) G	302 b. Place of Dispos	1 ACTON	KD - BA		c. Location - City of	
Baltimore,	Pages nent of t int: If Its		Burial 2 Cremation 3 C	Removal from State	cemetery, cren	natory or other place)	,		BAlto. M	
	permit. Pages Department of Important: If It eny injury or o		21. I gnatur of Funeral Service Lice		DAKLAW 22	Name and Address o	of Facility	Ito me	PA	,
ñ	P P P P P P P P P P P P P P P P P P P		Jaul M.	Stells	75	Name and Address of AUL STEll F	e Ro. Bai	HO.MO	21234	
			23a. Part . Enter the disease, or com shook, or heart failure. List only	plications that caused the one cause on each line.	death. Do not ente	er the mode of dying, s	such as cardiac or re	espiratory arrest	,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)			- CONC	SESTIV	E		
	/Medical Examiner		ſ	Due to (or as a cor	rsequence of):	OPATH	78			Months.
r<		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a cor	isequence of):					
	acuted ind transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
60,	icate be executed physician and s the burial-transit		193g(trig in dout) Edst	Due to (or as a cor	sequence or):					
98760	ificate be executed g physician and as the burial-transit	edical		d						
XOA	eath certifi attending   for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pro		Ectopic pregnancy			23d. Date of d	
	The law requires that the death cert tte has been signed by the attending age 2 should be detached for use	Physician/M	in the past 12 months?  1 Yes 2 XNo 9 Unknown	4☐Pregnant at time 9☐Unknown		Other (specify)			Month	Day Year
л О	that the de ed by the a detached	Phy	Part II. Other significant conditions	contributing to death but no	t resulting in the ur	nderlying cause given i	n Part I.	23e. Did tobac	cco use contribute	to the cause of death?
Vital Records,	uires that signed t	d by						1 🗆 Yes	2 □ No 3 □	Probably 4 Unknown
Ö	sw requir s been si 2 should l	Completed						24a. Was an	24b. Were	autopsy findings available o completion of cause of
ž		Com						autopsy performe 1 Yes 2	d?   death'	es 2 No
/ita	nysicien: Th nis certificate i director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other	6. Place of Death (C			
	Phys r this ral dir	1: To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatien 28b. Time of	28c. Injury at	Nursing Home	5 Residence  I. Describe how		pecify)
<u>0</u>	nding Ph tth. r: After th e funeral	atlor	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	ir) Injury	Work?	3 2 □ No			
Division of	l or Attendi after death Director: A	Certification:	3 Suicide 6 Could not be determined		At home, farm, stri	eet, factory, office	28f.	Location (Stree City or Town, S		Rural Route Number,
	urs aft ara! Di	Cer	Continue D	To the best of an	Leanning of the state of		data and class and	I due to the second	and manner	ne stated
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one) Certifying Pl	nysician: To the best of my miner: On the basis of examination and manner stated.	mination and/or inv	estigation, in my opini	ion, death occurred	at the time, date	and place, and d	ue to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	1.		29c. License nu	umber	29d	. Date signed (Mo	nth, Day, Year)
,	-		MACON	alm		D-00	12649		4-10-0	6
5	)		30. Name and address of person who	completed cause of death	(Item 23a) (Type,	D-OC Print) DSLER &	2. 7	NSO W	170	21204
	Sta	te	31. Date tiled (Month, Day, Year)	32. Begistrar's S	Signature	and s		- 307		7
	Registr		APR1 2 7	106 10000	All for	21/8/				
			and the same of	1	- Jan					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Hudson 03 2006 Ardel April 3:29a. Sallie 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Good Samaritan Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 SC 8. Date of Birth (Month, Day, 09 11 7. Age (In vrs. last birthday) 5. Social Security Number Year) Months Days Hours 1 □ M 2 □ F 85 20 242-32-5671 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 No Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number U.S.A. 21223 400 Millington Ave Apt 118 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No ff Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: Black ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic Worker na 4th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hattie Eaddy Hopson Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20024 19a. Informant's Name/Relationship (Type, Print) 1217 Carrollsburg PL SW, Washingtn, DC Gladys Marable-Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition YSBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Md Memorial Park 4/8/06 Randallstown, King 22. Name and Address of Facility 21. Signatur of Funeral Service Licensee March F/H West 21215 Baltimore, Md 4300 Wabash Ave, Approximate Interval Between On⇒t and Death enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by heart failure. List only one cause on each line. Immediate Cause (Final disease or condition

/Medical Examiner use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, been signed beat should be det within 24 hours after deam.

To the Funeral Director: After the further the fu

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-1 show

or Iteme 23a

"naturel",

f Heaith and Mental Hygiene.
Item 27 is marked other then "natur
other traumatic event, Ite Madical

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event ODES.

Pnysician

Examiner nast be notified at

Directo

Completed by Funeral

Be

ဂ

Physician/Medical Examiner

Be Completed by

Certification: To

Medical

State

Registrar

30 Name and as

31. Date filed (Month, Day, Year)

APR 1 2 2006

the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):  Due to (or as a consequence of):	Kalie mig Tailuye		hours
that initiated events resulting in death) Last	Due to (or as a consequence of):	arm (C		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	2	23d. Date of delivery Month Day Year
Part fl. Other significant conditions of	ontributing to death but not resulting in th	e underlying cause given in Part f.		se contribute to the cause of death?
Houte M	140cardia/	14faye7	24a. Was an autopsy performed? 1 ☐ Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical		26. Place of De	ath (Check only one)	
examiner? 1 Tes 2 No	Hospital: 1 ☐ Inpatient 2 ER/Outpa	itient 3 DOA Other: 4 Nursing	Home 5 Residence €	3 ☐Other (Specify)
27. Manner of Death 1 Xatural 5 Pending 2 Accident investigation			28d. Describe how infun	y occurred
3 Sutcide 6 Could not be determined	28e. Place of Injury - At home, farm building, etc. (Specify)	street, factory, office	28f. Location (Street and City or Town, State	d Number or Rural Route Number, )
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my knowledge, d niner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the cause(s) curred at the time, date and	and manner as stated. I place, and due to the cause(s)
29b. Signature and title of certifier	11111111	29c. License number	29d. Dat	te signed (Month, Day, Year)

D42Q83

HOS

		-	State of Maryland / Departr	ment of Health and Me	ental Hygien	0000	11432
	Dhyoini		1. Decedent's Name (First, Middle, Last)		Date of Death Month Da	ay Year	3. Time of Death
	Physicia /Medic	al	4a. Facility Name (If not institution, give street and number) 4b	City, Town, or Location of Death	04 0	8 06 c. County of Death	214º M
E	Examin	er	44. Facility Name (17 not institution, give street and number)  Young Hopking Ray 161	ANTIMORE.		BALTIN	lori-
	Funeral		S. Social Sociality Hamber	onths Days Hours Min.	B. Date of Birth (Month, Day, Year	9. Birthr	place (State or Foreign
	Director	-	219-76-6662 1 1 M AAF 43 Yrs. Wsual Residence of Decedent		CT. 8,1	962   MAR	YĹAND
	yland 10W		10a. State 10b. County 10c. City, Town or Location	n			Od. Inside City Limits
	Ba-f el	ctor	MD. N/A BALTI				MX es 2 No
	with th	Director		Of. Zip Code	10g. C	itizen of What Cou	ntry?
	ns 234	Funeral	617 N. HIGHLAND AVENUE  11. Maritat Status  12. Was Decedent Ever in U.S. 13. Was	21205  Decedent of Hispanic Origin? (Specis, specify Cuban, Mexican, Puerto Ri	ify Yes or No-	U.S.A.	
9	or Iter		1 Never Married 2 Married 1 Yes 2V No	s, specify Cuban, Mexican, Puerto Hi Yes 2⊠No <i>Specify:</i>	can, etc.)	Black, White,	
21215-0036	72 hours after death with the Maryland Insture!; or Items 23s or 28s-f ehow Leal Examinar in that be notified at	d by	3 ☐ Widowed 4 🏋 Divorced Year or Dates:		165	Specify: WH	
7	n nat	plete	(Specify only highest grade completed) (Give kind life. DO f	's Usual Occupation I of work done during most of working NOT use retired)		KIIIO OI DUSIIIOSSIII	dustry
212	giene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  1 1 HOUSE			DOMEST	IC
	be filed stal Hygi of other event.	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (	First, Middle, Maide MARLENE	n Sumame) BOSMA	NT.
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan t of Health and Mental Hygiene. If Item 27 is marked other then "naturet," or Items 23a or 28a-f show or other traumatic event, the Mastical Examinat man be multified as	ဥ	FRANK JAMES WILLIAMS  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Av	WILMA  ddress (Street and Number or Rural)			
	and 2 sealth an n 27 le			TA MOBILE DRIV	E, DUNDA	LK,MD.	21222
ore,	es 1 a of Hea filtern r othe		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  20b. Place of Disposition cemetery, cremator	ry or other place)		Location - City or T	own, State
altimore,	Pages tment of tant: If It jury or o		4 Donation 5 Other (Specify) TRINITY	EMETERY 4/13/0	-		, MARYLAND
Ball	permit. Page Department Important: If eny Injury o		Towns of James 700		STREET, B	RAL HOM	E E,MD. 2122
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	ne mode of dying, such as cardiac or	respiratory arrest,		Approximate Interval Between Onset and Death
ز	Physician /Medical		Immediate Cause (Finat disease or condition resulting in death)	Urnal hernie	ation		
	Examiner		Due to (or as a consequence of):				
	D =	ner	Sequentially list conditions,  Tany, reading to immediate gause. Enter Underlying				
1/6	be executed icien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last   C. Due to (or as a consequ ince of):				
8760,	ate be executed obysicien and the burial-transit	calE	d				
9	death certificate e attending phys	Physician/Medical	IF FEMALE:				-
Box	eath certific attending p for use as	lan/	23b. Was decedent pregnant in the past 12 months?  23c. if yes, outcome or pregnancy 1 Live birth 2 Fetal death 3 Ect	topic pregnancy her (specify)		23d. Date of deliv Month	ery Day Year
o.	that the de led by the a detached t	nysic	1 Yes 2 No 9 Unknown	(speedif)			
ď.	s that the gned by the	by PI	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.	23e. Did tobacco		the cause of death?
ğ	law requires t as been signe 2 should be	ted	Asthma interstitial hung His	260 <del>2</del> 6	1 ☐ Yes	20 No 3□Pro	
Vital Records,	62 CA	Completed	Mon-whenc andonyouthy.		24a. Was an autopsy performed?	24b. Were aut prior to co death?	opsy findings available ompletion of cause of
<u>a</u>	Thate pag	e Col	25. Was case referred to medical	26. Place of Death	1□ Yes V□N		2 No
₹	Physicien: this certific ral director,	8	examiner?	Other	e 5 Residence	6 ☐Other (Spec	ify)
n of	ding Ph	on: T	27. Manner of Death 1 Manner of Death 1 Manual 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at 25 Work?	8d. Describe how in	jury occurred	
Sio	ne att	catl	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No	8f. Location (Street	and Number or Ru	al Route Number
Division	al or Attend after death I Director: , d in by the f	Certification;	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Count not be determined  4 ☐ Homicide  4 ☐ Homicide  5 ☐ Count not be determined  4 ☐ Homicide  5 ☐ Count not be determined  5 ☐ Cou	ractory, office	City or Town, Sta		arriodic rearrisor,
	Hospita 4 hours Funere ely fille	edical C	23a Certifier (Check only one)  Contribut 2 Medical Examiner: On the basis of examination and/or investigand manner stated.				
	To the I within 2. To the I	Me	29b. Signature and title of certifier	29c. License number	29d. [	Date signed (Month	, Day, Year)
	, - 0		Vanor ah	RES-COD	- 0,	4/08/6	2<
	ľ		30. Name and address of person who completed cause of death (Item 23a) (Type, Prin	III) VIVIAN Asom	roat -	FWZ	toppies
	0		31. Date filed (Month, Day, Year) 32. Registrar's Signature	the there	e, Rath	More	you and
	St Regist	ate rar	APR 1 2 2006				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. U Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death April 06 Day **Physician** 2006 6:49 A M Eugene Raymond /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec. 11, 1935 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 1 XM 2 □ F Indiana Director 304-36-6613 70 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 10b County If item 27 is marked other than "neturel", or items 23a or 28e-1 show or other treumatic event, the Medical Examiner must be notified at 1 Yes 2 XNo Joppa Harford Director Maryland 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21085 USA 301 Foster Knoll Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Marned 1 ☐ Yes 2 🔀 No Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Department of Defense +8 Analytical Chemist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Grace Crawford Thomas Wesley Herd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 ment of Health a ent: If item 27 is 301 Foster Knoll Road, Joppa, Maryland 21085 Stephanie Herd/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Pagi Department Important: If eny injury or once. Holly Hill Cem. 4-10-2006 Baltimore, Maryland <sup>22. Name and Address of Facility</sup> McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21. Signitury / Funer / Service Licenses 21009 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acute My occardial Infarction Priysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 4rd, Kaymond # 000103897 Due to (or as a consequence of) Examiner attending physicien end for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 2 No 1 Yes 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 ☐ Yes 🔀 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No М death. investigation within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death accurred at the 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D35012

Registrar DHMH 17 Rev 1/2001

State

ORIGINAL

North Ave.

Bel Air, Md. 21014

mes

no

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LYNCH

J. Kevial

31. Date filed (Month, Day, Year)

		01-1	( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )			
		1 - For State Registrar	of Maryland / Departmer	nt of Health and M te of Death	01	106 111 21.
4 6	-	Registrar  1. Decedent's Name (First, Middle, Last) 1	Certificat	e or Death	Reg. No.	3. Time of Death
Physic	ian	11.00. 11.	DICK		A Month Day	200 DIA 2 M
/Medi		4a. Facility Name (If not institution, give street and	RICK	Town, or Location of Death	-1	County of Death
Exami	ner	1001 Mali	1.	2.11:00.00		NIA
Funeral	***	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday) If Unde	r 1 Year If Under 24 Hrs.	8. Date of Birth	9. Birthplace (State or Foreign
Funeral Director		215 30 6934 DEM 201		Days Hours Min.	(Month, Day, Year) 9-29-1832	(qountry)
4		Usual Residence of Decedent			1.01-1136	2 Tritosi ground
nylan show	_	10a. State 10b. County	10c. City, Town or Location			10d. Inside City Limits
e Ma	cto	Maryland NIA	Baltimo	ore		1 X Yes 2 No
ith th	Director	10e. Street and Number	10f. Zij	p Code	10g. Citize	en of What Country?
ath w	100	1821 Madison	Ave. 0	4217		USA
er de	Funeral	Amed	ecedent Ever in U.S. 13. Was Dece If Yes, spe	dent of Hispanic Origin? (Spe orly Cuban, Mexican, Puerto	cify Yes or No-	<ol> <li>Race - American Indian, Black, White, etc.</li> </ol>
36 saft	by F	1 Never Married 2 Married 1 X Yes, 3 Widowed 4 Divorced Year o	s 2 No Give 1 Yes r Dates:	2 SNo Specify:	S	Specify: Plank
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. thier than "natural", or Itema 23a or 28a-f show ont, the Medical Exerning or must be notified at	ed L	15. Decedent's Education	16a. Decedent's Usu	al Occupation	16b Kind	d of Business/Industry
157 n n 72	Completed	(Specify only highest grade complete	(Give kind of wo	ork done during most of workii	ng	,
d 212 lifed with Hygiene. ther thai	Eo	Elementary/Secondary (0-12) College	(1-4or 5+) Admin	istrator	Soc	ial Security
ethe other	BeC	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, Maiden S	(umame)
land ld be file fental Hy ked oth	To B	Alfred Hamk	prick	Berr	rice Mc	Ser
Maryla id 2 should lith and Meni	-	19a. Informant's Name/Relationship (Type, Print)	(mother) 19b. Mailing Address	s (Street and Number or Rura	l Route Number, City or	Town, State, Zip Code)
and 2 lealth a m 27 is		Mrs. Bernice Hay	nbrick 4116 M	lestcheste	r Rd. Bo	itto, Md. 21216
imore, Pages 1 at nent of Hea		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal fro	20b. Place of Disposition (Na cemetery, crematory or c	me of Dother place)	ate 20c. Loca	ation - City or Town, State
altimore, Maryland 21215-0036  init. Pages 1 and 2 should be filed within 72 hours after death with the Marylan between of Health and Mental Hygiene, ortant: if tem 27 is marked other than "natural", or Itema 23s or 28s-f show nighty or other traumatic event, the Medical Examination to confine a subject of the modified at the confine and the confine at the modified at the confine at the confin		4 □ Donation 5 □ Other (Specify)	Woodlawn	Cem. 4/12	2006 Wr	odlawn. Md.
Baltimo permit. Page Deportment of Important: If any njury or	4	21. Sign sture of Funeral Service Licensee	22. Name a	nd Address of Facility	uneral Hon	ma PA.
B F G F S	11.	Aslph di	Tuss zizz	W. North Ave	Balto.M	d.21216
		23a. Part . Enter the disease, or complications the shock, or heart failure. List only one cause of	at caused the death. Do not enter the moon each line.	de of dying, such as cardiac o	r respiratory arrest,	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	Acute venta	uala an	egh na	Onset and Death
/Medical Examiner		resulting in death)  Due	to (or as a consequence of):	,		(1)
			<i>-</i>	and a di		
A TANK	٠.	Sequentially list conditions, b.	coronay	arteg de	Alova	bas
	٠.	cause. Enter Underlying	to (or as a consequence of):	(1	ecore /	
	٠.	Cause (Disease or injury that initiated events c.	to (or as a consequence of):	he cardu	o vanc ula	dons Syes
	Examiner	Cause (Disease or injury that initiated events c.	to (or as a consequence of):	he cardu	o vanc ela	dons Syes
	cal Examiner	Cause (Disease or injury that initiated events c.	to (or as a consequence of):	he cardu	o care ela	dons Syes
	cal Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due	to (or as a consequence of):	he cardu	hes insce	dons Syes leve 10 gri
	cal Examiner	cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  C.  Due  d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	to (or as a consequence of):  anterior  to (or as a consequence of):  The the deoretical	the cardin	hes insce	dons Syes
	cal Examiner	Cause, Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  C. Due  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	to (or as a consequence of):  attrice  to (or as a consequence of):  deplication of pregnancy be birth 2   Fetal death   3   Ectopic pagnant at time of death   5   Other (s)	the cardin	hes insce	don Syes  lev 107-3  Id. Date of delivery
P.O. Box 68760, Antible death certificate be executed by the attending physicien and death of or use as the burial-transit	cal Examiner	Cause, Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  C.  Due  d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	to (or as a consequence of):  Arterior  to (or as a consequence of):  Coutcome of pregnancy  e birth 2   Fetal death egnant at time of death sknown	Le Les melle	kes unser	don Syes  lev 107-3  Id. Date of delivery
P.O. Box 68760, Antible death certificate be executed by the attending physicien and death of or use as the burial-transit	by Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last   C. Due  d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	to (or as a consequence of):  Arterior  to (or as a consequence of):  Coutcome of pregnancy  e birth 2   Fetal death egnant at time of death sknown	Le Les melle	kes unser	don Syes  Log 109-3  Id. Date of delivery  Month Day Year  e contribute to the cause of death?
cords, P.O. Box 68760, very requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	by Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last   C. Due  d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	to (or as a consequence of):  Arterior  to (or as a consequence of):  Coutcome of pregnancy  e birth 2   Fetal death egnant at time of death sknown	Le Les melle	23e. Did tobacco ust	Id. Date of delivery Month Day Year  e contribute to the cause of death?  To 3 Probably 4 Unknown  24b. Were autopsy findings available
cords, P.O. Box 68760, very requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	by Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last   C. Due  d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	to (or as a consequence of):  Arterior  to (or as a consequence of):  Coutcome of pregnancy  e birth 2   Fetal death egnant at time of death sknown	Le Les melle	23e. Did tobacco use 1 Yes 25  24a. Was an autopsy performed?	down Sayes  ld. Date of delivery  Month Day Year  e contribute to the cause of death?  No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?
cords, P.O. Box 68760, very requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	e Completed by Physician/Medical Examiner	Cause, Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last   IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	to (or as a consequence of):  Arterior  to (or as a consequence of):  Coutcome of pregnancy  e birth 2   Fetal death egnant at time of death sknown	Je Leo melle regnancy poecify)  cause given in Part I.	23e. Did tobacco use  1  Yes 2 2	dd. Date of delivery Month Day Year  e contribute to the cause of death?  To 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of
cords, P.O. Box 68760, very requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	Be Completed by Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last   LIF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	outcome of pregnancy e birth 2 Fetal death ganant at time of death but not resulting in the underlying of	Je Leo mello regnancy pacify)  cause given in Part I.	23e. Did tobacco use  1  Yes 2 2  24a. Was an autopsy performed? 1 Yes 2 2 No  (Check only one)	dd. Date of delivery Month Day Year  e contribute to the cause of death?  3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
cords, P.O. Box 68760, very requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examiner	Cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	to (or as a consequence of):  Arterior  to (or as a consequence of):  Outcome of pregnancy e birth 2 Petal death 3 Ectopic p agnant at time of death 5 Other (s) known o death but not resulting in the underlying of	Je Leo mello regnancy pacify)  Cause given in Part I.  26. Place of Death DA Other: 4 \( \triangle \triang	23e. Did tobacco use  1  Yes 2 2	dd. Date of delivery Month Day Year  e contribute to the cause of death?  3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
cords, P.O. Box 68760, very requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  Due  Due  Due  Due  Due  Due  Due  Du	to (or as a consequence of):  Arterior  to (or as a consequence of):  Outcome of pregnancy e birth 2 Petal death 3 Ectopic p agnant at time of death 5 Other (s) known o death but not resulting in the underlying of	Je Leo mello regnancy pacify)  Cause given in Part I.  26. Place of Death DA Other: 4 \( \triangle \) Nursing Hor	23e. Did tobacco use  1  Yes 2    24a. Was an autopsy performed? 1  Yes 2    (Check only one)  ne 5  Assidence 6	dd. Date of delivery Month Day Year  e contribute to the cause of death?  3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
cords, P.O. Box 68760, very requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	To Be Completed by Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last     IF FEMALE:	to (or as a consequence of):  Arterior  to (or as a consequence of):  coutcome of pregnancy be birth 2   Fetal death   3   Ectopic p egnant at time of death   5   Other (s) below the prognancy   5   Other (s) below to death but not resulting in the underlying of the of Injury   28b. Time of Injury   M  accord Injury - At home, farm, street, factor	regnancy pecify)  26. Place of Death DA Other: 4   Nursing Hor 28c. Injury at Work? 1   Yes 2   No	23e. Did tobacco use  1 Yes 2  24a. Was an autopsy performed? 1 Yes 2 No  (Check only one)  ne 5 Mesidence 6 28d. Describe how injury  28f. Location (Street and	dd. Date of delivery Month Day Year  e contribute to the cause of death?  3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
cords, P.O. Box 68760, very requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	Be Completed by Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last     IF FEMALE:	outcome of pregnancy e birth 2   Fetal death   5   Other (s) iknown    Inpatient 2   EFVOutpatient 3   Dt.    Inpatient 2   EFVOutpatient 3   Dt.    Ite of Injury (onth, Day Yeer)   ERVOutpatient   M	regnancy pecify)  26. Place of Death DA Other: 4   Nursing Hor 28c. Injury at Work? 1   Yes 2   No	23e. Did tobacco usu  1 Yes 2  24a. Was an autopsy performed? 1 Yes 2 No  (Check only one)  ne 5 Presidence 6  28d. Describe how injury	down Sayes  Log J  Id. Date of delivery Month Day Year  e contribute to the cause of death?  No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
cords, P.O. Box 68760, very requires that the death certificate be executed been signed by the attending physicien and should be detached for use as the burial-transit	Certification; To Be Completed by Physician/Medical Examiner	Cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	outcome of pregnancy e birth 2   Fetal death egnant at time of death   5   Other (si known   0   Death   1   Death   1    Inpatient 2   EPl/Outpatient 3   Death   1    Ite of Injury   At home, farm, street, factor ilding, etc. (Specify)	regnancy pecify)  Cause given in Part I.  26. Place of Death DA Other: 4   Nursing Hor Work? 1   Yes 2   No  y, office	23e. Did tobacco use  1 Yes 2  24a. Was an autopsy performed? 1 Yes 2 No  (Check only one)  ne 5 Presidence 6  28d. Describe how injury  28f. Location (Street and City or Town, State)	Ad. Date of delivery Month Day Year  e contribute to the cause of death?  No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  Other (Specify) occurred  Number or Rural Route Number.
Division of Vital Records, P.O. Box 68760, A Hoopital or Attending Physician: The law requires that the death certificate be executed the hours after death.  Funeral Director: After this certificate has been signed by the attending physicien and eight filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical Examiner	Cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last   IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	outcome of pregnancy e birth 2   Fetal death signant at time of death   5   Other (s) iknown    Inpatient   2   ER/Outpatient   3   Do the of Injury fonth, Day Yeer)   28b. Time of Injury   M ace of Injury - At home, farm, street, factor ilding, etc. (Specify)  the best of my knowledge, death occurred a basis of examination and/or investigation anner stated.	Jec Canclus  Jec C	23e. Did tobacco use  1 Yes 2  24a. Was an autopsy performed? 1 Yes 2 No  (Check only one)  ne 5 Presidence 6  28d. Describe how injury  28f. Location (Street and City or Town, State)  and due to the cause(s) a sed at the time, date and performed to the cause (s) a sed at the time time time time time time time tim	Id. Date of delivery Month Day Year  e contribute to the cause of death?  No 3 Probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  Other (Specify) occurred  Number or Rural Route Number.
Nivision of Vital Records, P.O. Box 68760, A or Attending Physician: The law requires that the death certificate be executed if the death.  Director: After this certificate has been signed by the attending physicien and in by the funeral director, page 2 should be detached for use as the burial-itransit	Certification; To Be Completed by Physician/Medical Examiner	Cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last    IF FEMALE:	to (or as a consequence of):  ATELIAN  to (or as a consequence of):  duod  outcome of pregnancy e birth 2   Fetal death 3   Ectopic p egnant at time of death 5   Other (s) known  o death but not resulting in the underlying of the of Injury   28b. Time of Injury   M  ace of Injury - At home, farm, street, factor ilding, etc. (Specify)  the best of my knowledge, death occurred e basis of examination and/or investigation anner stated.	regnancy pecify)  26. Place of Death  27. Place of Death  28c. Injury at Work?  1 Yes 2 No  1 at the time, date and place, a h, in my opinion, death occurred.  28c. License number	23e. Did tobacco use  1 Yes 2  24a. Was an autopsy performed? 1 Yes 2 No  (Check only one)  ne 5 Presidence 6  28d. Describe how injury  28f. Location (Street and City or Town, State)  and due to the cause(s) a sed at the time, date and p	dd. Date of delivery Month Day Year  e contribute to the cause of death?  No 3 probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  Other (Specify) occurred  Number or Rural Route Number.  Ind manner as stated.  Indicate the cause(s)  signed (Month, Day, Year)
Division of Vital Records, P.O. Box 68760, A. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical Examiner	Cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last    IF FEMALE:	to (or as a consequence of):  ATELIAN  to (or as a consequence of):  duod  outcome of pregnancy e birth 2   Fetal death 3   Ectopic p egnant at time of death 5   Other (s) known  o death but not resulting in the underlying of the of Injury   28b. Time of Injury   M  ace of Injury - At home, farm, street, factor ilding, etc. (Specify)  the best of my knowledge, death occurred e basis of examination and/or investigation anner stated.	regnancy pecify)  26. Place of Death  27. Place of Death  28c. Injury at Work?  1 Yes 2 No  1 at the time, date and place, a h, in my opinion, death occurred.  28c. License number	23e. Did tobacco use  1 Yes 2  24a. Was an autopsy performed? 1 Yes 2 No  (Check only one)  ne 5 Presidence 6  28d. Describe how injury  28f. Location (Street and City or Town, State)  and due to the cause(s) a sed at the time, date and p	dd. Date of delivery Month Day Year  e contribute to the cause of death?  No 3 probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  Other (Specify) occurred  Number or Rural Route Number.  Ind manner as stated.  Indicate the cause(s)  signed (Month, Day, Year)
Division of Vital Records, P.O. Box 68760, A Hoopital or Attending Physician: The law requires that the death certificate be executed the hours after death.  Funeral Director: After this certificate has been signed by the attending physicien and eight filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical Certification; To Be Completed by Physician/Medical Examiner	Cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last    IF FEMALE:	to (or as a consequence of):  ATELIAN  to (or as a consequence of):  duod  outcome of pregnancy e birth 2   Fetal death 3   Ectopic p egnant at time of death 5   Other (s) known  o death but not resulting in the underlying of the of Injury   28b. Time of Injury   M  ace of Injury - At home, farm, street, factor ilding, etc. (Specify)  the best of my knowledge, death occurred e basis of examination and/or investigation anner stated.	regnancy pecify)  26. Place of Death  27. Place of Death  28c. Injury at Work?  1 Yes 2 No  1 at the time, date and place, a h, in my opinion, death occurred.  28c. License number	23e. Did tobacco use  1 Yes 2  24a. Was an autopsy performed? 1 Yes 2 No  (Check only one)  ne 5 Presidence 6  28d. Describe how injury  28f. Location (Street and City or Town, State)  and due to the cause(s) a sed at the time, date and p	dd. Date of delivery Month Day Year  e contribute to the cause of death?  No 3 probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  Other (Specify) occurred  Number or Rural Route Number.  Ind manner as stated.  Indicate the cause(s)  signed (Month, Day, Year)
Division of Vital Records, P.O. Box 68760, A. To the Hoepital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification; To Be Completed by Physician/Medical Examiner	Cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	to (or as a consequence of):  Arterior  to (or as a consequence of):  outcome of pregnancy e birth 2   Fetal death 3   Ectopic p egnant at time of death 5   Other (s) elsewing of the of the sequence of):  I death outcome of pregnancy e birth 2   Fetal death 3   Ectopic p egnant at time of death 5   Other (s) elsewing of the underlying of the of linjury onth, Cay Yeer)  ace of Injury - At home, farm, street, factor elding, etc. (Specify)  the best of my knowledge, death occurred to basis of examination and/or investigation anner stated.  The Man D  ause of death (Item 23a) (Type, Print)  ER 3 C3 5 Old  The consequence of):  Are of the underlying of the	regnancy pecify)  26. Place of Death  27. Place of Death  28c. Injury at Work?  1 Yes 2 No  1 at the time, date and place, a h, in my opinion, death occurred.  28c. License number	23e. Did tobacco use  1 Yes 2  24a. Was an autopsy performed? 1 Yes 2 No  (Check only one)  ne 5 Presidence 6  28d. Describe how injury  28f. Location (Street and City or Town, State)  and due to the cause(s) a sed at the time, date and p	dd. Date of delivery Month Day Year  e contribute to the cause of death?  No 3 probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  Other (Specify) occurred  Number or Rural Route Number.  Ind manner as stated.  Indicate the cause(s)  signed (Month, Day, Year)
Division of Vital Records, P.O. Box 68760, To the Hoepital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification; To Be Completed by Physician/Medical Examiner	Cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	to (or as a consequence of):  Article  to (or as a consequence of):  outcome of pregnancy e birth 2   Fetal death 3   Ectopic p egnant at time of death 5   Other (s) egnant at time of death but not resulting in the underlying of the of Injury fonth, Cay Yeer)  ace of Injury - At home, farm, street, factor egliding, etc. (Specify)  the best of my knowledge, death occurred to basis of examination and/or investigation anner stated.  29  ause of death (Item 23a) (Type, Print)  R 3 6 3 5 Old  ause of death (Item 23a) (Type, Print)	regnancy pecify)  26. Place of Death  27. Place of Death  28c. Injury at Work?  1 Yes 2 No  1 at the time, date and place, a h, in my opinion, death occurred.  28c. License number	23e. Did tobacco use  1 Yes 2  24a. Was an autopsy performed? 1 Yes 2 No  (Check only one)  ne 5 Presidence 6  28d. Describe how injury  28f. Location (Street and City or Town, State)  and due to the cause(s) a sed at the time, date and p	dd. Date of delivery Month Day Year  e contribute to the cause of death?  No 3 probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  Other (Specify) occurred  Number or Rural Route Number.  Ind manner as stated.  Indicate the cause(s)  signed (Month, Day, Year)
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification; To Be Completed by Physician/Medical Examiner	Cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	to (or as a consequence of):  Arterior  to (or as a consequence of):  outcome of pregnancy e birth 2   Fetal death 3   Ectopic p egnant at time of death 5   Other (s) elsewing of the of the sequence of):  I death outcome of pregnancy e birth 2   Fetal death 3   Ectopic p egnant at time of death 5   Other (s) elsewing of the underlying of the of linjury onth, Cay Yeer)  ace of Injury - At home, farm, street, factor elding, etc. (Specify)  the best of my knowledge, death occurred to basis of examination and/or investigation anner stated.  The Man D  ause of death (Item 23a) (Type, Print)  ER 3 C3 5 Old  The consequence of):  Are of the underlying of the	regnancy pecify)  26. Place of Death  27. Place of Death  28c. Injury at Work?  1 Yes 2 No  1 at the time, date and place, a h, in my opinion, death occurred.  28c. License number	23e. Did tobacco use  1 Yes 2  24a. Was an autopsy performed? 1 Yes 2 No  (Check only one)  ne 5 Presidence 6  28d. Describe how injury  28f. Location (Street and City or Town, State)  and due to the cause(s) a sed at the time, date and p	dd. Date of delivery Month Day Year  e contribute to the cause of death?  No 3 probably 4 Unknown  24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No  Other (Specify) occurred  Number or Rural Route Number.  Ind manner as stated.  Indicate the cause(s)  signed (Month, Day, Year)

		1	For State Registrar	State of Ma		epartment of F Certificate of			ene <sub>g. No</sub> 2 0 0 6	11435
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		JESSIE MAE	JOHNSON				APRIL	8, 2006	5:30P M
7	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	dh
			RUXTON NURSIN	G HOME		PIKES			BALTIM	
	Funeral		5. Social Security Number 6. Se		(In yrs. last birtho	Months Davs	Hours Min.	8. Date of Birth (Month, Day, 10/27)	Year) 9. Bir	thplace (State or Foreign ountry) CAROLINA
	Director	-	210-03-7002		91 Yrs	s.		10/2//	7 1914 S	. CAROLINA
	and	-	Usual Residence of Decedent  10a, State 10b, County		10c. City, Town o	r Location				10d. Inside City Limits
	f ehe	0	MD BALTIM	ORE	OWING	S MILLS				1 ☐ Yes 2X No
	h the Maryland r 28a-f ehow	Director	10e. Street and Number		· · ·	10f. Zip Code		10	g. Citizen of What C	ountry?
	3a or		115 WILLOWBEN	ID DR., A	РТ.3В	211	17		USA	
36	within 72 hours after deeth with the Maryland ene. than "natural", or Nema 23e or 28e-f ehow he Medical Examinar must be notilied at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 [Yes 2X] N If Yes, Give Year or Dates:		13. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
21215-0036	hour tural		15. Decedent's Ed		16a. D	ecedent's Usual Occu	pation		16b. Kind of Business	s/industry
ָהַ	in 72	jet	(Specify only highest gra	de completed)	((	Give kind of work done fe. DO NOT use retire	during most of work	ring		,
2	withi lene. then	Completed	Elementary/Secondary (0-12) 9TH	College (1-4or 5-	+)	HOUSEK	EEPER		DOMESTI	C
	be filed within ntal Hygiene. ed other than " event, the Ma		17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, N	faiden Sumame)	
Maryland	thould be ad Mental marked c	To Be	ROBERT SPEARS	3			MARGAE	RET CHAV	/IS	
3	w = _ 3	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. N	Mailing Address (Stree	and Number or Rui	al Route Number,	City or Town, State,	Zip Code) 21201
	end 2 s saith an n 27 is ier trau		DENISE R. LANE	GRAND DAUGH	_ TER11	00 BOLTO	N ST.	APT. 308	BALTI	
ē,	ーエッセ		20a. Method of Disposition	5	20b. Place of D	isposition (Name of crematory or other pla			20c. Location - City o	
Ë	Pages nent of int: If It iry or o		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		MT. ZI	ON CEMET	ERY   4/1	13/06 1	LANSDOWN:	E, MD
Baltimore,	permit. Page Depertment of Important: If any Injury or once.		21. Signature of Femeral Service Licen	see A.	001.	22. Name and Address 4600 LIB	110			OME 21207 IMORE, MD
			23a. Pard Enter the disease, or company shock, or heart failure. List only	olications that caused	the death. Do no	t enter the mode of dy	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
			Immediat Cause (Final diseas or condition	one cause on each iin	1	las enlar [	Danie			Onset and Death
-	Pnysician /Medical		resulting in death)	a Due to (or as a	a consequence of		- thereis			
	Examiner									
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	Lidoriseculanda of	67				
V	cuted	Examin	Cause (Disease or injury that initiated events	c						
Ö,	cate be executed physicien and the burial-transit		resulting in death) Last	Due to (or as a	a consequence of	):				
8760,	ate b hysic the bi	dicai		. d						
9	e as	Me	IF FEMALE:	00- 11						
Division of Vital Records, P.O. Box	The law requires that the death certificate has been signed by the ettending page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 ☐Ectopic pregnand 5 ☐ Other (specify)	су		23d. Date of de Month	elivery Day Year
o.	that the bod by detaction	된	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in t	he underlying cause g	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
rds,	w requires been signi should be	ed by	1.					1 □ Ye	es 2□No 3□F	Probably 4 Donknown
၁၁	awre 2 she	Completed	N					24a. Was ar autops	y prior to	autopsy findings available completion of cause of
ř	The lav	E						perforn	ned?   death?	es 2 No
E	ian: rtifica ctor, i	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only on	e)	
<b>&gt;</b>	nysic nis ce direc	10	1 Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2□ER/Outp	atient 3 DOA		ome 5 ☐ Reside	nce 6 □Other (Sp	ecify)
o uo	Attending Physician: Ir death. ector: After this certifics by the funeral director, t		27. Manner of Death  1. Matural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day	y Year) 28b. Tir (Year) Inj	ury Wa	uryat ork? ∐Yes 2∐No	28d. Describe ho	ow injury occurred	
Divis	l or Atter efter des Director	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined			n, street, factory, office		28f. Location (St. City or Town	reet and Number or I n, State)	Rural Route Number,
_	To the Hospital or Attending Physician: The within 24 hours effer death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one) Certifying Pr	nysician: To the best of niner: On the basis of and manner sta	examination and	death occurred at the or investigation, in my	time, date and place opinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner a ate and place, and di	as stated. Le to the cause(s)
	o the	Me	29b. Signature and title of certifier			29c. Licer	nse number	2	9d. Date signed (Moi	nth, Day, Year)
	⊢ s ⊢ ŏ		Paymend Mu	hi mo		DA	17683		4/11/06	
	3		30. Name and address of person who		eath (Item 23a) (T					
	1		Raymone Millit 25	Main stre		_	untershown	MD 21	136	
	Sta	ate	31. Date filed (Month, Day, Year)		ar's Signature					
	Regist	rar	APR 1 2 2	nns A	J. H.	DORNE				

DHMH 17 Rev 1/2001

ORIGINAL

Physici	an	Decedent's Name (First, Middle,	Last)		_			1	Date of Dea	Day	Year	3. Time of Dear
/Medi		Darryl 4a. Facility Name (If not institution,	give street and nu	umber)	Jeste	4b. City, Town,	or Location of		irch (		006 ounty of Deat	3:59 A
Examir	ier	7615 Cypress Ro	7/15	Cypres	s Ave.	Dundal	k				altimo	
uneral irector		212-96-9036	5. Sex M 2 ☐ F	7. Age (In yrs. 41	last birthday) Yrs.	If Under 1 Year Months Days		Min. Al	Date of Birt Month, Da 19.2	7, 196	9. Birti Co 4 Mar	hplace (State or For cuntry) Cyland
show		Usual Residence of Decedent  10a. State 10b. County  MD Balt	imore	10c. Cit	ty, Town or Lo							10d. Inside City Lin
28a-f	ecto	10e. Street and Number			Duna	10f. Zip Code				10a, Citizen	n of What Co	
3a or	iDi	7615 Cypress	Ave.				2122	4		USA		,
ral, or itema 23a or 28a-i show Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed F	2 <b>X</b> No live		Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🛂 No	Hispanic Origi ban, Mexican,		Yes or Non, etc.)	- 14.	Race - Ame Black, White pecify:Whi	e, etc.
"natural", idical Exp	Completed	15. Decedent's (Specify only highest	Education grade completed,	)	16a. Deced	dent's Usual Occu kind of work done DO NOT use retire	pation during most of	ol working		16b. Kind	of Business/	Industry
r than "natur The Medical	idmo	Elementary/Secondary (0-12) 12th	College	(1-4or 5+)	life.	DO NOT use retire Disabl				37 /	_	
art,		17. Father's Name (First, Middle, L.	ast)			DISADI		's Name <i>(Fir</i>	st, Middle,	Maiden Su		
7 6	To Be	William Jest	ter					Kare	n Se	abol	t	
is mark numatic		19a. Informant's Name/Relationshi			19b. Mailir	ng Address (Stree	t and Number	or Rural Ro	ute Numbe	er, City or To	own, State, Z	Zip Code)
Item 27 is marke other traumatic		Carla B. Jest	cer / w			15 Cypr	ess A	ve. B	Balti			T Ctat-
Important: If Ite any Injury or ot once.		20a. Method of Disposition  1			cemetery, crer arkwoo	natory or other pla od Ceme	tery	4/4/0		Bal	tion - City or timor	e MD
any in		21. Signature of Funeral Service Li	1600	nell	U Co	2. Name and Addr Onnelly	Fune:	ral H	lome	of E		
		23a. Part1. Enter the disease, shock, or heart failure. List o	plications that	caused the deat	th. D not ent	er the mode of dy	ing, such as ca	ardiac or res	spiratory ar	rrest,		Approximate Interval Between
sician		Immediate Cause (Final disease or condition	17	eronan	- A	1- 0						Onset and Death
edical		resulting in death)				sen 1	1960	$\mathcal{L}$				
miner			Due to	(or as a conseq	tuence of):	ary V	· seal	2				
miner	Į.	Sequentially list conditions,	b. Due to	(or as a conseq		Hell.	hs.	<u></u>				
	miner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		o (or as a consequence)		Hell.	his					
	Examiner	if any, leading to immediate	c	o (or as a consequence of (or a))).	quence of):	Mell.	his					
ysician and he burial-transit	cai	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	c		quence of):	Hell.	103					
ittending physician and or use as the burial-transit	cai	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	c	o (or as a consequence of pregnibirth 2 Feta	quence of): quence of): ancy al death 3	Hell Lectopic pregnance Other (specify)				23d	t. Date of deli	ivery Day Year
by the attending physician and ached for use as the burial-transit	Physician/Medicai	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	c	o (or as a consequence of pregnation of pregnation of pregnation of donown	quence of):  quence of):  ancy al death 3 [ death 5 [	⊒Ectopic pregnanc ] Other (specify) _	sy		23e. Did t		Month	*
gned by the attending physician and be detached for use as the burial-transit	by Physician/Medicai	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  JF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	c	o (or as a consequence of pregnation of pregnation of pregnation of donown	quence of):  quence of):  ancy al death 3 [ death 5 [	⊒Ectopic pregnanc ] Other (specify) _	sy				Month contribute to	Day Year
is been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Medicai	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	o (or as a consequence of pregnation of pregnation of pregnation of donown	quence of):  quence of):  ancy al death 3 [ death 5 [	⊒Ectopic pregnanc ] Other (specify) _	sy		1 🗆 1	obacco use Yes 250	Month  contribute to	Day Year the cause of death obably 4 Unknow
ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Physician/Medicai	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	o (or as a consequence of pregnation of pregnation of pregnation of donown	quence of):  quence of):  ancy al death 3 [ death 5 [	⊒Ectopic pregnanc ] Other (specify) _	sy		1 🗆 Yas 24a. Was autop	obacco use Yes 2 1	Month  contribute to	Day Year  the cause of death obably 4  Unknown utopsy findings avail- completion of cause
ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	o (or as a consequence of pregnation of pregnation of pregnation of donown	quence of):  quence of):  ancy al death 3 [ death 5 [	⊒Ectopic pregnanc ∃ Other (specify) _ nderlying cause gi	ven in Part I. 26. Place o		1 🗆 Yas autop perfo 1 🗆 Yes	obacco use Yes 22N an ssy rmed? 22No	Month  contribute to  No 3 Proceedings of the contribute to contribute t	Day Year  the cause of death obably 4 Unknown stopsy findings available completion of cause
s certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c	utcome of pregnabirth 2 Feta prant at time of drown	ancy al death 3 [ death 5 [ sulting in the u	□Ectopic pregnance □ Other (specify) □ nderlying cause go	ven in Part I.  26. Place o her: 4 □ Nurs	of Death (C)	24a. Was autor perfo	obacco use Yes 2 1 an an ssy rimed? 2 1 No one) dence 6	Month  contribute to  No 3  Pr  24b. Were au prior to c death? 1  Yes  Other (Spec	Day Year  of the cause of death obably 4 \( \subseteq \text{Unknown} \) utopsy findings avail- completion of cause 2 \( \subseteq \text{No} \)
s certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	C	utcome of pregnution at time of december o	ancy al death 3 [ death 5 [ sulting in the u	Ectopic pregnanc Other (specify)  Interpretation of the second of the se	ven in Part I.  26. Place o her: 4 □ Nurs	of Death (C) sing Home 28d.	24a. Was autor perfo	obacco use Yes 2 N an an an by rimed? 2 No one)	Month  contribute to  No 3  Pr  24b. Were au prior to c death? 1  Yes  Other (Spec	Day Year  of the cause of death obably 4 \( \subseteq \text{Unknown} \) utopsy findings avail- completion of cause 2 \( \subseteq \text{No} \)
s certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	C	utcome of pregnation to the pregnant at time of donown death but not result in the pregnant at time of donown death but not result in the pregnant at time of donown death but not result in the pregnant death but not result in the pre	ancy al death 3 [ death 5 [ sulting in the u ] ER/Outpatier  28b. Time of Injury	Ectopic pregnanc Other (specify)  Interpretation of the second of the se	ven in Part I.  26. Place of ther: 4 \( \text{Nurs} \) iny at 7/7  Yes 2 \( \text{N} \)	of Death (C) sing Home 28d. o	24a. Was autor period 1 Yes neck only co	obacco use Yes 2 1 2 2 3 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3	Month  contribute to  No 3 □ Pri  24b. Were au prior to c death? 1 □ Yes  □Other (Spec	Day Year  of the cause of death obably 4 \( \subseteq \text{Unknown} \) utopsy findings avail- completion of cause 2 \( \subseteq \text{No} \)
s certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	Certification: To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	C	utcome of pregnabirth 2 Feta pant at time of drown  death but not reserved to the preserved	ancy al death 3 death 5 death 6 death	Deet, Jactory, office	ven in Part I.  26. Place of ther: 4 \( \text{Nurse} \) iry at \( \text{vk?} \) ] Yes 2 \( \text{N} \)	of Death (C/sing Home 28d.	24a. Was autor performed to the following th	obacco use Yes 2 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Month  contribute to  No 3  Pr  24b. Were au prior to c death? 1  Yes  Other (Spec	Day Year  of the cause of death obably 4 \( \subseteq \text{Unknown} \)  utopsy findings available completion of cause 2 \( \subseteq \text{No} \)  cify)  ural Route Number, is stated.
certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	C	utcome of pregnabirth 2 Feta Inant at time of donown death but not research and formation of the control of the	ancy al death 3 death 5 death 6 death	Deet, Jactory, office	26. Place of ther:  4   Nursing at wh?  Yes 2   Nursing at opinion, death	of Death (CF) sing Home 28d. 0 28f.	24a. Was autop performer to the time.	obacco use  Yes 2 1 1 2 2 1 1 2 2 1 1 1 2 1 1 1 1 1 1	Month  contribute to  No 3   Proceedings of the contribute to contribute to the cont	Day Year  of the cause of death obably 4 \( \subseteq \text{Unknown} \)  utopsy findings available completion of cause 2 \( \subseteq \text{No} \)  cify)  ural Route Number, is stated.
s certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	edical Certification: To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	C	utcome of pregnabirth 2 Feta prant at time of drown death but not research and from the drown death but not research and from the drown death but not research and from the drown death but not research and from the drown death but not research drown death drown death drown drown death drown dro	ancy al death 3 [ death 5 [ sulting in the u  BER/Outpatier  28b. Time of Injury  ome, farm, str  owledge, deatl attion and/or in	DEctopic pregnance Other (specify)  Int 3 DOA Other  At 3 DOA Other  Int 3 DOA Interpretation  Int 3 DOA Interpretation  Inter	26. Place of ther:  27. All Nursell Nu	of Death (Cr sing Home 28d. o 28f.	24a. Was autor period of the control	obacco use Yes 2 1 an ssy sy sy sy sy sy an 22 No one) dence 6 1 how injury of cause(s) and date and pla 29d. Date s	Month  contribute to  No 3   Proceedings of the contribute to the	Day Year  the cause of death obably 4  Unknot atopsy findings avail- completion of cause 2  No  cify)  ural Route Number, a stated.
s certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to d.  23c. If yes, or 1 Live 4 Preg 9 Unkr.  Is contributing to a contributing to a contributing to a contributing to a contributing to a contributing to a contributing to a contributing to a contribution or a contribution	utcome of pregnabirth 2 Feta pant at time of drown death but not restricted by the following of Injury and Day Year)  The best of my knobasis of examinar ner stated.	ancy al death 3 [ Jeath 5	Deet, Jactory, office  at 3 DOA  at 3 DOA  at 3 DOA  at 3 DOA  at 3 DOA  at 3 DOA  at 28c. Injugate  by a deet, Jactory, office  at a deet, Jactory, office  at a deet, Jactory, office  by a deet, Jactory, office  at a deet, Jactory, office  at a deet, Jactory, office  by a deet, Jactory, office  at a deet, Ja	26. Place of ther:  27. All Nursell Nu	of Death (Cr sing Home 28d. o 28f.	24a. Was autor period of the control	obacco use Yes 2 1 an ssy sy sy sy sy sy an 22 No one) dence 6 1 how injury of cause(s) and date and pla 29d. Date s	Month  contribute to  No 3   Proceedings of the contribute to the	Day Year  the cause of death obably 4  Unknow  utopsy findings avail- completion of cause 2  No  cify)  ural Route Number, is stated. to the cause(s)  h. Day, Year)

ack

10 5 5

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarAmend Item #31 Per DVR G854 CERTIFICATE OF Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 9:27 PM APRIL 2006 WTT.T.A HORTENSE **JOHNSON** 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1713 Appleton St. Baltimore 8. Date of Birth (Month, Day, Year) 9. Birthplace (Str. Country) Apr. 23, 1926 Maryland If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 X F Director 79 214-26-2966 Usual Residence of Decedent death with the Maryland show 10a State 10c. City, Town or Location 10d. Inside City Limits or Items 23s or 28a-f shov 1 AYes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1713 Appleton St. Funeral 21217 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian other traumatic event, the Madical Examiner: Black, White, etc. illed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Completed by 3 ☐ Widowed 4 [XDivorced 'natural', B1ack 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nu any injury or other traumatic event, If a Media 2006. Elementary/Secondary (0-12) College (1-4or 5+) 2yrs Waitress Hotels 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ျှ Henry Holland Rebecca Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $4608\ 72nd\ Ave$  . 19a. Informant's Name/Relationship (Type, Print) Victorine C. Woods/Niece Hyattsville, MD. 20784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory 4-10-2006 Alexandria, VA. 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility
Marshall's Funeral Home, Inc. 1/ax 4217 9th St. N.W. Washington, DC 20011 23a. P3d. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury nce of) by Physician/Medical Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician as the IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy ŏ Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No the detached 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ed bluods 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed 2 No 1 ☐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other. 2 1 🗌 Yes 2 🗷 No 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 □Other (Spečily) this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records, P.O. Box 68760, in by the funeral director, or Attending death. after death Director: within 24 hours a To the Funeral C completely

> State Registrar

Medical

NO am 31. Date filed (Month, Day, Year)

determined

4 Homicide

(Check only one)

29b. Signatule and title of certifier

30. Name and address of person who complete

29a. Certifier

955In 32. Registrar's Signature

cause of death (Item 23a) (Type, Print)

and manner stated

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Eutan St.

		1- I-or State Registrar		•		ate of Dea	lth and Menta th	R	eg. No. 200	6
Physici cal Exam		Decedent's Name (First)	Middle,Last)	These	on			2. Date of Dea Month April 8, 20	Day Year	3. Time of Deat 10:45
>		4a. Facility Name (if not in 4000 Fords Lane		street and number)		4b. City, Baltii	Town, or Location of D		4c. County of De	ath
Funeral Director		5. Social Security Number	6. Sex		(In yrs. last birth	•	ler 1 Year If Under 2		th (MM/DD/YYYY) 9. 1 1-1966	Birthplace (State or Country)
×.	1	Usual Residence of Deced	dent		10c. City, Town	<u> </u>		0		10d. Inside City
nd show any ice.	<u>_</u>	mb	ounty		-01	timore				1 <b>X</b> res 2
IND 61613-00030 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number	1	11.10		10f. Zij	Code	1	0g. Citizen of What Co	ountry?
th the 23a or notifie	a Di		,	e #1C			21215	/ Ci/ - V N	HOW H	Since Ledical Disc
r death w or items	Funeral	<ul><li>11. Marital Status</li><li>1 Never Married 2</li></ul>	Married	12. Was Decedent I Armed Forces? 1 Yes 2	No No		ent of Hispanic Origin? ify Cuban, Mexican, Pu		White, etc	erican Indian, Blac
after d	by Fi	3 Widowed 4	Divorced	If Yes, Give Year or Dates:	A) No	1 Yes 2	No specify:		Specify: 3	lack
3, IND 21213-0030 and 2 should be filled within 72 hours afte featht and Mental Hygiene. tten 27 is marked other than "natural", traumatic event, the Medical Examiner.	ted b	15. Decedent's Education  Elementary/Secondary		y highest grade com College (1-4 or 5	during		Occupation (Give kind	d of work done	16b. Kind of Busines	s/Industry
JSD thin 72 ne. than '	Completed	Elementaly/Secondary	(0-12)	College (1-4 of 5	Fo	most of working	re. DO NOT use retire	far.	Food	ervice
E, MID 21213-0030 I and 2 should be filed within 7 Health and Mental Hygiene, item 27 is marked other than r traumatic event, the Medica		17 Father's Name (First, I	Middle, Last)			1 (4 )4. 1	16.Mother's i	lame (First, Middle	Maiden Surname)	
Id be f dental narked event,	o Be	Oohn Ui	CKL1	300	194	Mailing Addres	S (Street and Nilmhe	ma. Oo	hnson mber, City or Town, St	ate Zin Code)
d 2 shou d 2 shou lth and N n 27 is n rumatic	<u>٥</u>	Sk. ma Tol	ASOU	Siste		209 / 5	den Hole	Avo. B	Ho mi	212/
at at us		20a. Method of Disposition	-	/	20b. Place of	of Disposition (Na or or other place		Date	20c. Location - City	or Town, State
autimore, mit. Pages I a spartment of He portant: If ite lury or other ti			emation 3 ther Specify:	Removal from Sta	tina	Memoria	1 Park 1	H15/06	Baltin	ore m
<b>SAITIM</b> permit. Pag Department Important:					1 - 2 4 - 1			, , ,	1	-1-1000
		21. Signature of Funeral S	ervice License	ee		22. Name and	Address of Facility	pone Fu	neral Ser	VICES
Dail Dermit. Depart Impor injury		Vaughn (!	Mr	une	0	22. Vame and 8728	L'berty k	eene Fu 2d. fand	A /	mo all
n 링크트를 Physician		23a. Part Enter the disea failure. List only one	ase, or complic	Cations that caused to	the death. Do no	22 Wame and 8728 of enter the mode	Address of Facility  Liberty  of dying, subh as card	Ed. Rand	A /	Approximate Between Or
<b>n</b> 80 = E		23a, Part Enter the disea	ase, or complic cause on each	cations that caused to h line. Seizure Di	sorder	22 Name and 8728 of enter the mode	Address Factly  Liberty  of dying, subtracted	Ed. Rand	alkstown,	Approximate Between On
n ឱ្យ ៩ ទី Physician /Medical		23a. Part Enter the disea failure. List only one Immediate Cause (Final d	ase, or complic cause on each lisease a. eath) D	cations that caused the line.	sorder	22 Vame and 6728 of enter the mode	Address of Facility  The House of dying, subtraction	Ed. Rand	alkstown,	Approximate Between Or
n ឱ្យ ៩ ទី Physician /Medical	iner	23a. Part Inter the disea failure. List only one Immediate Cause (Final dor condition resulting in de Sequentially list condition if any, leading to immedia cause. Enter Underlying	ase, or complice cause on each lisease a. eath) Do s, b. te Do Cause	cations that caused to h line. Seizure Di	sorder quence of):	22. Vame and 22. Value and 22.	Address Facily Liberty of dying, suba a card	Ed. Rand	alkstown,	Approximate Between On
Physician /Medical Examiner	xaminer	23a. Part Enter the disea failure. List only one Immediate Cause (Final dor condition resulting in do Sequentially list condition if any, leading to immedia	ase, or complice cause on each lisease a. eath) D. s., te D. Cause lated c.	cations that caused to h line.  Seizure Divue to (or as a conse	sorder quence of):	22. Vame and 22. Value and 22.	Address of Facility  The House of dying, subtraction	Ed. Rand	alkstown,	Approximate Between On
Physician /Medical xaminer	al Examiner	23a, Part Inter the disea failure. List only one Immediate Cause (Final dor condition resulting in do Sequentially list condition if any, leading to immedia cause. Enter Underlying (Disease or injury that init events resulting in death)	ase, or complice cause on each lisease a. eath) D. s., te D. Cause lated c.	cations that caused to h line.  Seizure Divue to (or as a conseque to (or a) conseque to (or a) conseque to (or a) conseque to (or a) conseque to (or a) con	sorder quence of): quence of):			Pd. Pand iac of respiratory arr	alkstown,	Approximate Between On
Physician /Medical xaminer		23a. Part Enter the disea failure. List only one Immediate Cause (Final dor condition resulting in do Sequentially list condition if any, leading to immedia cause. Enter Underlying (Disease or injury that init events resulting in death)  X UNPENDED	ase, or complice cause on each lisease a. eath) D. s., te D. Cause lated c.	cations that caused to h line.  Seizure Di line to (or as a conserue to (or a)))).	sorder quence of): quence of): quence of): en#1,23a,		Address Facily Address Facility of dying, subtraction to the second seco	Pd. Pand iac of respiratory arr	est, shock, or heart	Approximate Between Or Deat
Physician /Medical xaminer		23a, Part Inter the disea failure. List only one Immediate Cause (Final dor condition resulting in do Sequentially list condition if any, leading to immedia cause. Enter Underlying (Disease or injury that init events resulting in death)  INPENDED  IF FEMALE: 23b. Was decedent pregna	ase, or complike cause on each isease a. eath)  b. te Cause inted Last  d.	cations that caused to h line.  Seizure Divue to (or as a conseque to (or a) conseque to (or a) conseque to (or a) conseque to (or a) conseque to (or a) con	sorder quence of): quence of): quence of): en#1,23a,	27,perME,g	856,6/7/06 t	ed. Pandiac of respiratory arr	alkstown,	Approximate Between On Deat
Physician /Medical xaminer		23a. Part Inter the disea failure. List only one Immediate Cause (Final dor condition resulting in dor condition resulting in dor condition if any, leading to immedia cause. Enter Underlying (Disease or injury that init events resulting in death)  X UNPENDED  IF FEMALE: 23b. Was decedent pregnapast 12 months?	ase, or complication cause on each isease a. eath)  b. te D. Cause c. C. Cause d. Last D. D. A. C. D. D. A. C. D. D. D. C. D. D. D. D. D. D. D. D. D. D. D. D. D.	cations that caused to h line.  Seizure Di line to (or as a conseque to (or a))).	sorder quence of): quence of): quence of): em#1,23a, e of pregnancy	27, perME, g	2856,6/7/06 t 3 ∏Ectopic pr	ed. Pandiac of respiratory arr	est, shock, or heart	Approximate Between On Deat
Physician /Medical xaminer		23a. Part Enter the disea failure. List only one Immediate Cause (Final dor condition resulting in do Sequentially list condition if any, leading to immedia cause. Enter Underlying (Disease or injury that init events resulting in death)  X UNPENDED  IF FEMALE: 23b. Was decedent pregnapast 12 months?  1 Yes 2 No 9	ase, or complike cause on each lisease a. eath)  s, b. te DCause inted Last D. d. X. Ant in the	cations that caused to h line.  Seizure Di line to (or as a conserve to (or a conserve to (or a conserve to (or a conserve to (or as a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a	sorder quence of): quence of): quence of): em#1,23a, e of pregnancy time of death	27, perME, g	28 <b>56,6/7/06</b> t 3 ∏Ectopic pr	Ed. Pandiac of respiratory arm	est, shock, or heart  23d. Date of delive Month	Approximate Between On Death
Physician /Medical xaminer	by Physician/Medical	23a. Part Inter the disea failure. List only one Immediate Cause (Final dor condition resulting in dor condition resulting in dealing to immedia cause. Enter Underlying (Disease or injury that init events resulting in death)  IX UNPENDED  IF FEMALE: 23b. Was decedent pregnapast 12 months?	ase, or complike cause on each lisease a. eath)  s, b. te DCause inted Last D. d. X. Ant in the	cations that caused to h line.  Seizure Di line to (or as a conserve to (or a conserve to (or a conserve to (or a conserve to (or as a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a	sorder quence of): quence of): quence of): em#1,23a, e of pregnancy time of death	27, perME, g	2856,6/7/06 t 3 ∏Ectopic pr	E egnancy	est, shock, or heart	Approximate Between On Deat
Physician /Medical xaminer	by Physician/Medical	23a. Part Enter the disea failure. List only one Immediate Cause (Final dor condition resulting in do Sequentially list condition if any, leading to immedia cause. Enter Underlying (Disease or injury that init events resulting in death)  X UNPENDED  IF FEMALE: 23b. Was decedent pregnapast 12 months?  1 Yes 2 No 9	ase, or complike cause on each lisease a. eath)  s, b. te DCause inted Last D. d. X. Ant in the	cations that caused to h line.  Seizure Di line to (or as a conserve to (or a conserve to (or a conserve to (or a conserve to (or as a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a	sorder quence of): quence of): quence of): em#1,23a, e of pregnancy time of death	27, perME, g	28 <b>56,6/7/06</b> t 3 ∏Ectopic pr	egnancy  23e. Did to 1 Ye 24a. Was	23d. Date of delive Month  abacco use contribute as 2 No 3 Pan 24b. Were	Approximate Between On Death  To the cause of de robably 4 Un autopsy findings a
Physician /Medical xaminer	by Physician/Medical	23a. Part Enter the disea failure. List only one Immediate Cause (Final dor condition resulting in do Sequentially list condition if any, leading to immedia cause. Enter Underlying (Disease or injury that init events resulting in death)  X UNPENDED  IF FEMALE: 23b. Was decedent pregnapast 12 months?  1 Yes 2 No 9	ase, or complike cause on each lisease a. eath)  s, b. te DCause inted Last D. d. X. Ant in the	cations that caused to h line.  Seizure Di line to (or as a conserve to (or a conserve to (or a conserve to (or a conserve to (or as a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a	sorder quence of): quence of): quence of): em#1,23a, e of pregnancy time of death	27, perME, g	28 <b>56,6/7/06</b> t 3 ∏Ectopic pr	egnancy  23e. Did to 1 Ye 24a. Was autor perfo	23d. Date of delive Month  23d. Date of delive Month  23d. Date of delive Month  24b. Were prior to death	Approximate Between Or Deat  To the cause of de robably 4 Ur autopsy findings a o completion of ca ?
Physician /Medical xaminer	Completed by Physician/Medical	23a. Part Enter the disea failure. List only one Immediate Cause (Final dor condition resulting in do Sequentially list condition if any, leading to immedia cause. Enter Underlying (Disease or injury that init events resulting in death)  X UNPENDED  IF FEMALE: 23b. Was decedent pregnapast 12 months?  1 Yes 2 No 9	ase, or complic cause on each isease a. eath)  b. te D. Cause isted C. Last D. X.  ant in the Unknown conditions	cations that caused to h line.  Seizure Di line to (or as a conserve to (or a conserve to (or a conserve to (or a conserve to (or as a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a	sorder quence of): quence of): quence of): em#1,23a, e of pregnancy time of death	27, perME, g	28 <b>56,6/7/06</b> t 3 ∏Ectopic pr	egnancy  23e. Did to 1 Ye  24a. Was autop perfo 1 Yes	23d. Date of delive Month  23d. Date of delive Month  23d. Date of delive Month  24b. Were prior to death	Approximate Between Or Deat  To the cause of de robably 4 Ur autopsy findings a o completion of ca ?
VITAI RECORDES, P.O. BOX 68/60, striam: The law requires that the death certificate be executed  was permitted by the attenting physician and director, page 2 should be detached for use as the burial - transit  in fine control page 2 should be detached for use as the burial - transit	Be Completed by Physician/Medical	23a. Part Linter the disea failure. List only one Immediate Cause (Final dor condition resulting in do Sequentially list condition if any, leading to immedia cause. Enter Underlying (Disease or injury that init events resulting in death)  X UNPENDED  IF FEMALE: 23b. Was decedent pregnapast 12 months?  1 Yes 2 No 9  Part II. Other significant of	ase, or complike cause on each lisease a. eath)  s, b. te DCause interest and d. IX  ant in the Unknown  conditions	cations that caused to h line.  Seizure Di line to (or as a conserve to (or a conserve to (or a conserve to (or a conserve to (or as a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a	sorder quence of): quence of): quence of): em#1,23a, e of pregnancy time of death	27, perME, g Fetal death Other (Spa	2856,6/7/06 to a Tectopic procify)  g cause given in Part I	egnancy  23e. Did to 1 Ye  24a. Was autop perfo 1 Yes neck only one)	23d. Date of delive Month  23d. Date of delive Month  23d. Date of delive Month  24b. Were prior to death	Approximate Between Or Deat  To the cause of de robably 4 Ur autopsy findings a o completion of ce ? Yes 2
VITAI RECORDES, P.O. BOX 68/60, striam: The law requires that the death certificate be executed  was permitted by the attenting physician and director, page 2 should be detached for use as the burial - transit  in fine control page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	23a. Part Inter the disea failure. List only one Immediate Cause (Final dor condition resulting in do Sequentially list condition if any, leading to immedia cause. Enter Underlying (Disease or injury that init events resulting in death)  X UNPENDED  IF FEMALE: 23b. Was decedent pregnapast 12 months?  1 Yes 2 No 9  Part II. Other significant of examiner? 1 Yes 2 No 9	ase, or complike cause on each isease a. eath)  b. te Cause inted Cause inted Cause inted Last D Unknown Conditions  medical Ho	cations that caused to heline.  Seizure Directo (or as a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve to (or a conserve	sorder quence of): quence of): quence of): em#1,23a, te of pregnancy time of death but not resulting	27, perME, g Fetal death Other (Spe	2856,6/7/06 to a Ectopic precify)  g cause given in Part I  26. Place of Death (Clause)  Other A N  28c. Injury at Work?	egnancy  23e. Did to 1 Ye  24a. Was autor perfo 1 Yes  eck only one)  28d. Describe	23d. Date of delive Month  23d. Date of delive Month  2 No 3 P  24b. Were prior to death 2 No 1	Approximate Between On Deat  To the cause of de robably 4 Un autopsy findings a o completion of cae? Yes 2
VITAI RECORDES, P.O. BOX 68/60, striam: The law requires that the death certificate be executed  was permitted by the attenting physician and director, page 2 should be detached for use as the burial - transit  in fine control page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	23a. Part Enter the disea failure. List only one Immediate Cause (Final dor condition resulting in do Sequentially list condition if any, leading to immedia cause. Enter Underlying (Disease or injury that init events resulting in death)  X UNPENDED  IF FEMALE: 23b. Was decedent pregnapast 12 months?  1 Yes 2 No 9  Part II. Other significant of examiner?  1 Yes 2 No 9	ase, or complike cause on each lisease a. eath)  s, b. te DCause interest and d. IX  ant in the Unknown  conditions	cations that caused to hold line.  Seizure Diversity to for as a consequence to (or as a consequence t	sorder quence of): quence of): quence of): em#1,23a, te of pregnancy time of death but not resulting	27, perME, g Fetal death Other (Spe	2856,6/7/06 to a Tectopic procify)  g cause given in Part I  26. Place of Death (Chapter 1/4   N	egnancy  23e. Did to 1 Ye  24a. Was autor perfo 1 Yes  eck only one)  28d. Describe	23d. Date of delive Month  23d. Date of delive Month  23d. Date of delive Month  24b. Were prior to death 2 No 1   Residence 6 Other	Approximate Between On Deat  To the cause of de robably 4 Un autopsy findings a o completion of cae? Yes 2
VITAI RECORDES, P.O. BOX 68/60, striam: The law requires that the death certificate be executed  was permitted by the attenting physician and director, page 2 should be detached for use as the burial - transit  in fine control page 2 should be detached for use as the burial - transit	To Be Completed by Physician/Medical	23a. Part Linter the disea failure. List only one Immediate Cause (Final dor condition resulting in dor condition resulting in death)  Sequentially list condition if any, leading to immedia cause. Enter Underlying (Disease or injury that init events resulting in death)  X UNPENDED  IF FEMALE: 23b. Was decedent pregnapast 12 months?  1 Yes 2 No 9  Part II. Other significant of examiner?  1 Yes 2 No 9  25. Was case referred to rexaminer?  1 Yes 2 No 9  27. Manner of Death  1 Natural 5  2 Accident  3 Suicide 6	ase, or complic cause on each isease a. eath)  S, b. te D. Cause inted C. Last D. A. Mant in the Conditions  The conditions of the conditi	cations that caused to holine.  Seizure Director (or as a consequence to (or a	sorder (quence of):  quence of):  quence of):  em#1,23a,  e of pregnancy time of death  but not resulting  the 2 ER/O	27, perME, g Fetal death Other (Spe g in the underlyin utpatient 3	2856,6/7/06 to a Ectopic precify)  g cause given in Part I  26. Place of Death (Clause)  Other A N  28c. Injury at Work?	egnancy  23e. Did to 1 Yes  24a. Was autop perfo 1 Yes  neck only one) ursing Home 5 28d. Describe	23d. Date of delive Month  23d. Date of delive Month  23d. Date of delive Month  23d. Date of delive Month  24b. Were prior to death 21 No 1   Residence 6 Othow injury occurred	Approximate Between On Deat  To the cause of de robably 4 Un autopsy findings a o completion of ca ? Yes 2  her: Scene
VITAI RECORDES, P.O. BOX 68/60, striam: The law requires that the death certificate be executed  was permitted by the attenting physician and director, page 2 should be detached for use as the burial - transit  in fine control page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	23a. Part Linter the disea failure. List only one Immediate Cause (Final dor condition resulting in decause. Enter Underlying (Disease or injury that init events resulting in death)  I UNPENDED  IF FEMALE: 23b. Was decedent pregnapast 12 months?  1 Yes 2 No 9  Part II. Other significant of examiner?  1 Yes 2 Namer of Death  1 Natural 5  20 Accident  3 Suicide 6  4 Homicide	ase, or complike cause on each isease a. eath)  b. te	cations that caused to h line.  Seizure Director (or as a consequence to (or a	sorder quence of): quence of pregnancy quence of quence of): quence of pregnancy quence of quence of): quence of pregnancy quence of que	27, perME, g  Fetal death  Other (Spa	2856,6/7/06 to a Sectopic process of the sectopic proc	egnancy  23e. Did to 1 Ye 24a. Was autor perfo 1 Yes ack only one) ursing Home 5 28d. Describe 28f. Location ( or Town, 5	23d. Date of delive Month  23d. Date of delive Month  23d. Date of delive Month  24b. Were prior to death 2 No 1   Residence 6 Othow injury occurred  Street and Number or State)	Approximate Between On Deat  To the cause of de robably 4 Un autopsy findings a o completion of ca ? Yes 2 her: Scene
VITAI RECORDES, P.O. BOX 68/60, striam: The law requires that the death certificate be executed  was permitted by the attenting physician and director, page 2 should be detached for use as the burial - transit  in fine control page 2 should be detached for use as the burial - transit	Certification: To Be Completed by Physician/Medical	23a. Part Enter the disea failure. List only one Immediate Cause (Final dor condition resulting in dor condition resulting in death)  Sequentially list condition if any, leading to immedia cause. Enter Underlying (Disease or injury that init events resulting in death)  X UNPENDED  IF FEMALE: 23b. Was decedent pregna past 12 months?  1 Yes 2 No 9  Part II. Other significant of examiner? 1 Yes 2 No 9  25. Was case referred to rexaminer? 1 Yes 2 Natural 5 Accident 3 Suicide 6 4 Homicide 29a. Certifier (Check only 1 Certific Check only 1 Certifier (Check o	ase, or complic cause on each isease a. eath)  b. te	cations that caused to home.  Seizure Directo (or as a conseque to (or a	sorder quence of):	27, penME, g Fetal death Other (Spe g in the underlyin utpatient 3 Time of Injury arm, street, factor	3 Ectopic precify)  3 Ectopic precify)  g cause given in Part I  26. Place of Death (Cf DOA Other; 1 Yes 2 No y, office building, etc.	egnancy  23e. Did to 1 Yes  24a. Was autor performance of the second one of the second	23d. Date of delive Month  23d. Date of delive Month  23d. Date of delive Month  23d. Date of delive Month  24b. Were prior to death 21 No 1   Residence 6 Othow injury occurred	Approximate Between Or Deat  To the cause of de robably 4 Ur autopsy findings a o completion of ca ? Yes 2  Ther: Scene  Rural Route Number tarted.
so that the death certificate be executed  Example 2. Box 68/60,  Example 2. Box 68/60,  Example 3. Box 68/60,  Example 3. Box 68/60,  Example 4. Box 68/60,  Example 5. Box 68/60,  Example 6. Box 68/60,  Example 6. Box 68/60,  Example 6. Box 68/60,  Example 6. Box 68/60,  Example 6. Box 68/60,  Example 7. Box 68/60,  Example 7. Box 68/60,  Example 7. Box 68/60,  Example 7. Box 68/60,  Example 7. Box 68/60,  Example 7. Box 68/60,  Example 7. Box 68/60,  Example 7. Box 68/60,  Example 7. Box 68/60,  Example 7. Box 68/60,  Example 7. Box 68/60,  Example 8. Box 68/60,  Example 8. Box 68/60,  Example 9. Box 68/60,  Ex	To Be Completed by Physician/Medical	23a. Part Linter the disea failure. List only one Immediate Cause (Final dor condition resulting in decause. Enter Underlying (Disease or injury that init events resulting in death)  I UNPENDED  IF FEMALE: 23b. Was decedent pregnapast 12 months?  1 Yes 2 No 9  Part II. Other significant of examiner?  25. Was case referred to rexaminer?  27. Manner of Death  1 Natural 2 Accident 3 Suicide 6 4 Homicide 29a. Certifier (Check only	ase, or complic cause on each isease a. eath)  S, te D Cause inted Last D  Ant in the  Unknown  conditions  medical  Pending Investigation  Could not b determined  ying Physicia and Examiner:	cations that caused to heline.  Seizure Directo (or as a consequence to (or as	sorder quence of):	27, perME, g Petal death Other (Spa g in the underlyin utpatient 3 Time of Injury arm, street, factor ath occurred at th nvestigation, in m	3 Ectopic precify)  3 Ectopic precify)  g cause given in Part I  26. Place of Death (Cf DOA Other; 1 Yes 2 No y, office building, etc.	egnancy  23e. Did to 1 Yes  24a. Was autor performance of the second one of the second	23d. Date of delive Month  23d. Date of delive Month  23d. Date of delive Month  2 No 3 Pan 24b. Were prior to death 2 No 1 Pan 24b. Were prior to death 2 No 1 Pan 24b. Were prior to death 2 No 1 Pan 24b. Were prior to death 25 No 1	Approximate Between Or Deat  Approximate Between Or Deat  To be to the cause of de robably 4 Ur autopsy findings a o completion of ca ? Yes 2  her: Scene  Rural Route Numb tarted.

State Registrar

31. Date filed (Month, Day, Year)



			r lease i	State of Maryla				•	iene	
			For State Registrar	, , , ,		tificate of			eg. No.	11439
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day Year	3. Time of Death
	/Medic Examir	al	Hiram James  4a. Facility Name (If not institution, give s			4b. City, Town	, or Location of Dea	April 6	2006 4c. County of Dea	14:30 M
i)			Upper Chesapeake			Bel Ai			Harford	
V.,	Funeral Director		438-42-6697	14 OD 5	i. last birthday) Yrs.	If Under 1 Year Months Day			, 1935 Mis	thplace (State or Foreign buntry) SSISSIPPI
	land ow		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
	with the Maryland a or 28a-f show	Funeral Director	Maryland Harford  10e. Street and Number	Ed	lgewood	10/ 7: 0-1-			0	1 Tes 2 1 No
	With the man	Dir	1002 F Magnolia	Woode C+		10f. Zip Code 21040			IOg. Citizen of What Co USA	ountry?
	death ims 23	nera		12. Was Decedent Ever in Armed Forces?	U.S. 13.			Specify Yes or No- erto Rican, etc.)		
21215-0036	n 72 hours after death with the Maryla "natural", or itams 23a or 28a-f shov idical Exercities must be rediffed at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No ff Yes, Give Year or Dates:		Tes, specify Co		nto nican, etc.)	Specify:	e, etc. 31ack
5-0	"natural",	eted	15. Decedent's Edu (Specify only highest grade	cation completed)	16a. Deced	lent's Usuaf Occ kind of work don	upation ne during most of w red)	orking	16b. Kind of Business	
121	within ene. than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			red)		Air Dans	
d 2	filed withing Hygiene. other than	Be Co	17. Father's Name (First, Middle, Last)		Milit	ary	18. Mother's N	ame (First, Middle,	Air Force Maiden Surname)	
/lar	2 should be and Mental Is marked o	ToB	Paul John Jenkins	s, Sr.			Annie	Virginia	a Conner	
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. item 27 is marked other than ' other traumatic event, The Ma		19a. Informant's Name/Relationship (Ty						r, City or Town, State,	
	of Health item 27		Frank H. Jenkins 20a. Method of Disposition		Place of Dispo	sition (Name of			dewood, MI 20c. Location - City or	
Jou	Pages ent of nt: If it y or o		1 Burial 2 ☐ Cremation 3 MR 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, crer	natory or other p. Memoria	· · · · · · · · · · · · · · · · · · ·	1	Alexandria	
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service License					Home, P.A.		12.
8	Depa Impo any i		Multo 11	Emgv)	1	317 Cok	esbury Ro	oad, Abino	don, MD 21	009
	Physician /Medical		23a. Part1. Enter the disease, of complishock, or heart failure. List only or Immediate Cause (Finaf disease or condition resulting in death)	cations that caused the dealer cause on gach line.  2nc+nl  Due to (or as a conse	ia lopu	the mode of d	ying, such as cardi	ac or respiratory arr	est,	Approximate Interval Between Onset and Death
*	Examiner		Sequentially list conditions,			/				
\. /	nsit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (in as a conse	queлсе of).					
6	an and rial-tra	Examin	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
8760,	hysicia	licai		-						
). Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fel 4 □ Pregnant at time ot 9 □ Unknown	al death 3	Ectopic pregnan Other (specify)	icy		23d. Date of de Month	ivery Day Year
P.0	that the	Phy	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause o	aven in Part I	23e. Did to	bacco use contribute to	the cause of death?
Records,	equires sen sign	ted by				,		1 □ Y		obably 4 Unknown
Rec	The law ite has b	omple						24a. Was a autops perfore	y prior to ned? death?	utopsy findings available completion of cause of 2 No
Vital	cian: ertifica ector, j	Bec	25. Was case referred to medical examiner?				26. Place of De	eath   Check only on	1	10,110
of \	Physician: r this certific ral director,	2	1 ☐ Yes 27 Alo	ospital: Inpatient 2 [	ER/Outpatien	3 DOA			ence 6 Other (Spe	city)
on	ding Ith. After funer	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of Infury	28c. Inj W	uryat ork? ⊡Yes 2⊡No	28d. Describe no	ow injury occurred	
Division of	or Attending fler death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	nome, farm, str ify)			28f. Location (Si City or Town	treet and Number or Ri n, State)	ural Route Number.
٦	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2.	Medical Ce	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examir	sician: To the best of my kner: On the basis of examin	lowledge, death	occurred at the	time, date and place	ce, and due to the courred at the time, d	ause(s) and manner as ate and place, and due	s stated. to the cause(s)
	vithin 2 o the omple	Mec	29b. Signature and title of certifier	and manner stated.			nse number		9d. Date signed (Mont	
	->-ō		> SIL	MD		7	34652		April 7.	2006
	notl		30. Name and address of person who co	mpleted cause of death (Ite	m 23a) (Type,	1	'A 1	1	ry hand a	Tiniv
7	٨٠,		31. Date filed (Month, Day, Year)	#2. Registrar's Sign	vorh nature	Huchu	1 25/	AIN MIN	ry Inhol o	nul y
	Sta Registr		APR 1 2 2006	March &	Rose	E)			1	

Hiram

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. UU 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) April Year 2:09 **Physician** 2006 04 R. Johnson, Jylvesten /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORG-AGNES HEALTH CARE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 102M 2□ F 43 220-78-8347 Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State ir than "naturel", or iteme 23a or 28a-f ehow The Medical Examinar must be notified at 1 2 76s 2 No Bultimore MD Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 45212 6425 Eustern Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 Yes 20 No Specify Baltimore, Maryland 21215-0036 Black þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 27 le marked other than "n eny injury or other traumatic event, Ita Misall 2006. College (1-4or 5+) Elementary/Secondary (0-12) Lubones ROOFING 1211 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be m. Sylvesten R. Johnson, Rose 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) there Bultmore MB 21284 6425 Eustern Johnson Rosemanie 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 15/06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Acensee Ham P Chi 902120M 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the ettending physicien and Due to (or as a consequence of) Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown Ö À ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Records, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ARDIOMYOPATHY Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 X No 1 Yes 2 No this certificate of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) the funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Yes 2 XNo 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural
2 Accident Division 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier P19923 APRIL Swarhala 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST AGNES HOSPITAL, BALTHORE, MO CUUAR CHALA, KOMPELLA, HD

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JOHN SON

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10:46 am Elizabeth I. Kozenski 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Hose dale

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
Dec. 01, 1935 Franklin Square 5. Social Socurity Number 6. Hospital Center Itimore 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□ M 2↓ F Maryland 219-32-6201 70 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23s or 28a-f ahow the Medical Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Harford Md. Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 Box Hill S. Parkway 21009 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 white 1 ☐ Yes 2 No Š 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "eny Injury or other treumatic event the manual or the treumatic event the manual or the treumatic event the manual or the ma Elementary/Secondary (0-12) 12 years College (1-4or 5+) cashier grocery store Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Bunce Elizabeth Gay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 255 Wyndham Hill Drive, Fishersville, Va. 22939 Elizabeth C. Edwards/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 4/12/06 Baltimore, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Buin a Wille Schimunek Funeral Home of Bel Air, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

21014

Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration preumonia **Physician** 2 days /Medical Due to (or as a consequence of): **Examiner** OPD Gequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner attending physicien and for use as the burial-transit Multiarticu ar Syears Due to (or as a consequence of): P.O. Box 68760 nges two Physician/Medical 2days near IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Month Day 4☐Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed After this certificate I funeral director, pag 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death Check only one examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺ No 1 Inpatient 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural Injury 5 Pending within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 □Yes 2 □No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PO02239 Comm 9000 Franklin Square Drive Baltimore, Hd. 21237 30. Name and address of person o complet REDILEY A UCHUSON 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

enski

0

06-0	2388	
Lee.	William	

Please Type or Print in Black Indelible Ink

e, William		St 1- For State Registrar	tate of Mary	land / [		tment of ficate of		d Mental H	ygiene	Reg. No.	200	5	The state of the s
Physician edical Examine	-	Decedent's Name (First, Midd William	<sub>le,Last)</sub> Henry	Lee,	Sr.				2. Date of I Month April 7,	Day	Year		e of Death
	ı	4a. Facility Name (if not institution  Johns Hopkins Bayvie		number)		41	o. City, Town, or I Baltimore	Location of Death	1	40	c. County of Dea	ath	
Funeral Director		5. Social Security Number 217–22–7474	6. Sex		n yrs. last	t birthday) Yrs.	If Under 1 Year Months Days		1.	6, 1	, (	Country)	(State or Foreign
any		Usual Residence of Decedent 10a. State 10b. County		10	c. City, To	own or Locatio	n					10d. l	nside City Limits
*	5 I	Maryland Harf	ord		Stre	eet						1 🗓	Yes 2 X No
the Maryland a or 28a-f sh tified at onc	3	10e. Street and Number					10f. Zip Code				izen of What Co	untry?	
5-0036  led within 72 hours after death with the Maryland Hygiene other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once the Medical Examiner must be notified at once of marylother Hygine 1 Director of the Complete		3127 Anna Drive 11. Marital Status	12. Was De	ecedent Eve	er in U.S.	13. Was	21154 Decedent of Hisp	panic Origin? ( S	pecify Yes or		SA 14. Race - Am	erican Ind	lian. Black.
or items 23		1 Never Married 2 XM		Forces?	No		s, specify Cuban,				White, etc.		,,
s after d rral", or niner m			vorced If Yes, Give Y		947		-X	specify				ack	
21215-0036 lid be filed within 72 hours affice dental Hygiene narked other than "natural", event, the Medical Examiner	ב	<ol> <li>Decedent's Education (Spe Elementary/Secondary (0-12)</li> </ol>	,	ade comple (1-4 or 5+)		uring	s Usual Occupation	,	work done	16b I	Kind of Busines	s/Industry	1
5-0036 iled within 77 Hygiene 1 other than the Medical	Collibrated	10		(, , , ,			ingine do Ni Ingineer	or use retired)		С	ivil Se	rvic	e
5-01 iled w Hygie I other the N		17. Father's Name (First, Middle	, Last)					8.Mother's Name	e (First, Midd				
2121 2121 Mental B marked c event,		Walter Earn 19a. Informant's Name/Relations				19h Mailing	Address (Street	Anna and Number or	(U/K)		cMillia		nde)
MD 2 d 2 shou th and I n 27 is r tumatic	-	Chico Lee/Son	**************************************				Burlingt				-		
- E & E E		20a Method of Disposition  1 X Burial 2 Cremation	n 3 Removal	from State			ion (Name of cerr		Date		Location - City		
- 0 0 E -		4 Donation 5 Other S		nom orace	Clar	ks U.M	i. Ch. Ce	em. 04	-13-20	006	Bel Ai	r,Ma	ryland
Baltin permit, 1 Department Importa	C	21 Signature of Funeral Service	· · Da			22. Na MCC	me and Address Omas Fur	of Facility neral Ho	me, P	Α.			
Physician		23a. Part I. Enter the disease, or		causetine	death. D						n Mary	~hh	21009 roximate Interval
/Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	Marikin In In		ence of):							Bet	ween Onset and Death
recuted and - transit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d.										
60, nte be exe hysician a burial -	2	UNPENDED	AMENDED	Ite	n 281	f per M	EG85404	/19/06dh	b				
687 ertifica ding pl		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	he 1 Live	, outcome of birth gnant at tim	100	2 Feta	al death 3 [ er (Specify)	Ectopic pregn	ancy	23	d Date of delive Month	ery Day	Year
Box ne death c the atten hed for us	3			nown	.=.=				20 0				
P.O.		Part II. Other significant condit	ions contributing	to death bu	ut not rest	uiting in the ur	iderlying cause g	iven in Part I.	1	Yes 2	use contribute ✓ No 3 P		4 Unknown
of Vital Records, P.O. ng Physician: The law requires that the ther this certificate has been signed by neral director, page 2 should be detach by T. D. Completed by D. C. Completed by D. C. Completed by D. C. Completed by D. C. Completed by D. C. Completed by D. C. Completed by D. C. C. Completed by D. C. C. C. C. C. C. C. C. C. C. C. C. C.	completed by								p	utopsy erform <u>ed</u> ?	prior to death	complet	indings available
I Re	2	25. Was case referred to medical	el .				26.Place	of Death (Check	1 Y only one)	es 2 N	lo 1 🗸	Yes	2 No
Vital Reco	2	examiner? 1  Yes 2 No	Hospital: 1	Inpatient	2 EI	R/Outpatient	3 DOA	Other Nursi	ng Home 5	Reside	ence 6 Oth	ner:	
on of ending Phath.  or: Aftert the funeral			dilig	e of Injury hth Day, Year) 2006	7	8b. Time of Inj 7:40		y at Work? ′es 2 ✔ No	28d. Descr Driver au		ury occurred collision		
Division of Vital F Hospital or Attending Physician: Ed hours after death. Formeral Director: After this certificately filled in by the funeral director.		3 Suicide 6 Cou	ermined (Specify	y) Major	Road	/ Highway	, factory, office bu		Rt. 24 @	W Ring	Factory Re	ad, Be	te Number City Phail Rd.
the the		29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	Physician: To the basis	S OI CAMIIIII	nowledge, ation and	, death occurre l/or investigation	ed at the time, da on, in my opinion,	te and place, and death occurred	d due to the o at the time, o	cause(s) ar late and pla	nd manner as si ace, and due to	arted Be the caus	lAir,MD
To To	Ž	29b. Signature and title of certific					29c. License			29d	Date signed (A	fonth, Da	y, Year)
		Maryonte 1)	re Mull	use of doct	h /ltom or	30)	O.C.N	И.E.		Apr	il 8, 2006		
11+1		<ol> <li>Name and address of person Margarita Korell MD.</li> </ol>	Assistant M				nn Street, Ba	altimore, MD	21201				
Stat Registra	ч	31. Date filed (Month, Day, Year) APR 1 2		Registrar's	Signature	fran	K)						

ORIGINAL

DHMH 17 Rev 1/2001 OCME 10/2003

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician LITOFSKY** Apoil Month HOWARD 1:35 AM 10 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UPPER CHESAPEAKE HOSPITAL **HARFORD** BEL AIR If Under 1 Year If Under 24 Hrs. 8. Date of Birth MAR. 6, 1946 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F MD 60 Yrs Director 213-46-1761 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No HARFORD FOREST HILL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 306 WILLRICH CIRCLE, UNIT M USA 21050 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Specify. 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be in and 2 should be fi Health and Mental H tam 27 is marked off LITOFSKY OSTROWSKY LEON SARAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 WILLRICH CIRCLE, UNIT M - FOREST HILL, MD 21050 Health itam 27 i BARBARA LITOFSKY / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If its
eny injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State SHAAREI ZION CEMETERY 4/11/2006 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 10 hours /Medical Due to (or as a consequence of) Examiner 20 hours reunonio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Certification; To Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2000 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner?
Yes 2 No 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No naral Director: A filled in by the fu 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide To the Hospital o within 24 hours aff To the Funaral Di completely filled in 1 Cadifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

ofs Ky, Howard

o.

of Vital

Division

44

1

31. Date filed (Month, Day, Year) Registrar 2006

au

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D0053568

apacke

29d. Date signed (Month, Day, Year)

April 10, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- For Amend Item 26 per verb., G854 04/12/06dbb Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** March 30, 2006 Charles Walter Lane 10:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b City Town or Location of Death Examiner 13801 York Road #A-9 Baltimore Cockeysville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Months Days Yrs. Director 216-09-4736 93 Mar 31, 1912 Maryland Usual Residence of Decedent 10d Inside City Limits 10a State 10c, City, Town or Location 10b County 28a-f show traumatic evant. the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Director Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21030 USA 13801 York Road #A-9 Itams 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 administrator U.S. Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be finand Mental Financed of Charles Walter Lane Edith McMullen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 s ment of Health an sent: If item 27 is: 440 N. E. Town Terrace Jensen Beach, FL 34957 Douglas Lane/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ö \* 4 X Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee

Ronald S. Wade Director

Ronald S. Wade Director

Baltimore, MD 21201

23a. Part1. Eller the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or near failure. List only one cause on each line. 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE /Medical Due to (or as a consequence of): **Examiner** RONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 Yes 2 No Vital Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Mursing Home 5 X Residence 6 Other (Specify) <u>S</u> 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year, 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Ite 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

APR I 2 ZUL

31. Date filed (Month, Day, Year)

ORIGINAL

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Dey Month Year **Physician** John 1530 2006 /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Deeth 4c. County of Deeth Examiner Augsburg Lutheran Home N/A Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 08/05/1921 Birthplace (State or Foreign Country) 5. Social Securify Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 84 1 M 2 □ F 194-16-2880 PA Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No MD Directo Baltimore City Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 6901 Jones View Drive 3B 21209 IISA by Funeral 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2. 2. No If Yes, Give 14. Raca - American Indian. 11. Maritel Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify: White 3- Widowed 4 □ Divorced Yeer or Dates: Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) unknown unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Lillian Keck John Leo Mack 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Roberta Kae Sarubin 6901 Jones View Drive 3B Baltimore, MD 21209 20b. Placa of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) Apr 1 ☐ Buriel 2 ☑ Cremation 3 ☐ Removal from State Beltsville, Maryland Chesapeake Crematory Inc. 2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Fecility Cremation and Funeral Alternatives 8717 Green Pastures Drive Baltimore, Maryland 21286 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Hiple sclevesis Immediate Cause (Final disease or condition resulting in death) Medical cars Examiner Due to (or es a consequence of): Examine physician and s the burial-transit Attending Physician: The law requires that the death certificate be assecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es a consequence of) attending ph ate has been signed by the paga 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2tho 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed 21ZIN 1 ☐ Yes 2 ☐ No 11 | Yes cartificate : After this cartifica a funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2[] No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 12 Naturel 5 Pending s aftar death. 1 ☐ Yes 2 ☐ No investigation 2 Accident tha 6 ☐ Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) fillad in by 4 Homicide ŏ To the Hoepital o within 24 hours af To the Funeral DI completaly filled in 29a. Certifier 🖆 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner as steted. Medical 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner steted. 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature end title of cartifier D37573 7,2006 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Reisterstown MD 37-5 Main Registrer's Signature 31. Date filed (Manth Ray: 1 Year) 2006 State Registrar

	200		1 - State Registrar		artment of Health and Martificate of Death	lental Hygie		11446
	Physici	ian	1. Decedent's Name (First, Middle, Last)	4.		2. Date of Death Month April	Day 2006	3. Time of Death
	/Media	cal	Robert James Moore, S  4a. Facility Name (If not institution, give street and numb		4b. City, Town, or Location of Death	April .	7, 2006 4c. County of Deat	10:22 A M
	Examir	ner	3507 Hiss Avenue	5.7	Baltimore		Balti	
\$	Funeral Director	-		Age (In yrs. last birthday 68 Yrs.	) if Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye Oct. 12.	9. Birth 1937 Vi	hplace (State or Foreign untry) TGLNIA
	pu »		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or L	coation			10d. Inside City Limits
	Manyla f ehov	ō	Maryland Baltimore	Too. Only, Town of E	Baltimore			1 ☐ Yes 2 ☑ No
	r 28e-	Directo	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Co	untry?
	23a o		3507 Hiss Avenue		21234		U.S.A.	
320	within 72 hours after death with the Maryland sne. than "natural", or items 23e or 28e-f ehow he Madical Exeminer must be notitled at	by Funeral	11. Marital Status  1 Never Married 2 X Married  1 Never Married 2 X Married  3 Widowed 4 Divorced  12. Was Deced Armed Forc  1 X Yes 2  If Yes, Give	ent Ever in U.S. 13 es?  No No No	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 ☒ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: Who	e, etc.
9500-6121	ithin 72 hou ne. nen "netura	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-2) 5+	16a. Dec (Giv life.	edent's Usual Occupation e kind of work done during most of work. DO NOT use retired)	ing	b. Kind of Business/	,
V	iled w dygier ther th		17. Father's Name (First, Middle, Last)	Seni	or Executive Staff	(First, Middle, Mai	.S. Gover	nment
yland	should be find Mental h marked of umatic even	To Be	Ernest Edward Moore		Nellie	Gray Li	ndsey	
Mar	ges 1 and 2 should it of Health and Mer if item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Type, Print) Mrs. Lois W. Moore (wi		ing Address (Street and Number or Rura 7 Hiss Avenue, Bali			(ip Code)
ā,	s 1 an f Heal item 2 other		20a. Method of Disposition	20b. Place of Disp			. Location - City or	Town, State
Ē	nit. Pages artment of ortent: if it injury or o		1		Valley Mem'l 4/11,	12006 Ti	nonium, M	aryland
baltimore,	permit. Departrimports eny inju		21. Signature   Funeral Service Licensee		22. Name and Address of Facility Sch 19705 Belair Road, 1			
8760,	Certificate be executed from the purishing physicien and physicien and transitions as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that mittated events c.	as a consequence of): as a consequence of): as a consequence of):	Collen Cancer			Interval Between Onset and Death
O. Box 6	the death y the etter sched for u	hysician/Me	in the past 12 months?	it at time of death 5	□Ectopic pregnancy □ Other (s <i>pecify)</i>		23d. Date of deli Month	ivery Day Ye <i>a</i> r
ds, F	es tha gned be de	by P	Part II. Other significant conditions contributing to dea	th but not resulting in the	underfying cause given in Part I.	23e. Did tobac 1 ☐ Yes		the cause of death?
Kecord	e faw has b	Completed				24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
VITAL	sicien: Th certificate rector, pag	0	25. Was case referred to medical		26. Place of Deat	1 ☐ Yes 2 ☑	No 1 ☐ Yes	269 No
ō	Phys this ral di	tion: To B	27. Manner of Death  Shatural 5 Pending  28a. Date of (Month,	natient 2 ER/Outpatie		me 5 PResidence 28d. Describe how		cify)
DIVISION	tel or Attending s after death. el Director: After ed in by the fune	Certification:	3 Suicide 6 Could not be 28e. Place o	f Injury - At home, farm, s , etc. <i>(Specify)</i>	treet, factory, office	28f. Location (Stree City or Town, S	t and Number or Ru tate)	iral Route Number,
	To the Hospitel or At within 24 hours after or To the Funerel Director moletely filled in by	edical (	203. Certifier (Check only one) 2 Medical Examiner: On the base and manner	is of examination and/or i	ith ornured at the time date and plane nvestigation, in my opinion, death occurr	and due to the caus ed at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the l	ž	29b. Signature and title of partifier		29c. License number	29d.	Date signed (Monti	h, Day, Year)
	. 1		m. I intell stoy	of physicia	n 019714	4/1	0/06	
	1541		30. Name and address of person who completed cause	of death (Kem 23a) (Type	Nent Rive Ste	Timen N	1.777	4
	Sta	ate	31. Date filed (Month, Day, Year)	jistrar's Signature	AP .	)	J. 2	1
	Registi	rar	APR 1 2 2006 Au	H. Ales	West .			

			For State Registrar	State of Maryla	nd / Depa	artme		and M	ental Hygie	ene 0 0 6	
	Dharaisi		1. Decedent's Name (First, Middle, La	st)					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medi		MARGARET HO	FFMANN McI	NTYRE				APRIL	05 2006	12:30PM
	Examir		4a. Facility Name (If not institution, giv				, Town, or Locatio			4c. County of Death	
	78		SINAI HOSPITAL O				ALTIMORE			N/A	
	Funeral		5. Social Security Number 6. S 138-32-5813	THE OFFICE	i. last birthday) Yrs.	If Unde Months		er 24 Hrs. Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birth	place (State or Foreign intry)
	Director		Usuat Residence of Decedent	□ <sup>M 2</sup> X <sup>F</sup>   67	TIS.				Oct. 16,	1938 New	Jersey
_\	land w		10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
ني	Mary	ŏ	Maryland Balti	more	Baltim	ore					1 ☐ Yes 2 ☐ No
Mangave	ours after death with the Marylar rel', or Itema 23e or 28e-f ehow Exeminer must be notified at	Je C	10e. Street and Number		Darcin		p Code		100	. Citizen of What Cou	
3	38 of	<u>-</u>	735 Regester Ave	ทาย			2121	12			
Ž	death	nere	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Dece	edent of Hispanic ( ecify Cuban, Mexic		cify Yes or No-	U.S.A. 14. Race - Ameri	ican Indian,
	or its	2	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2∑ No If Yes, Give	1				Hican, etc.)	Black, White	, etc.
ع کے	Sur Sur Sur Sur Sur Sur Sur Sur Sur Sur	d b	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 🗌 Yes	2 No Specif	ry:		Specify: Wh	nite
300	within 72 hours after death with the Maryland and.  and.  than "natural", or Itema 23a or 28e-f ehow than "natural", or Itema 21a on 28e-f ehow and a Maryland and a Maryla	Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra	ducation ide completed)	16a. Deced	dent's Usi kind of w	ial Occupation ork done during m ise retired)	ost of workir	16	6b. Kind of Business/Ir	ndustry
7 5	P P S S S S S S S S S S S S S S S S S S	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	1						2 1 1 1
McINTyve,	Hygie of the reference	ပိ	17. Father's Name (First, Middle, Last)	5+ years		Buage	et Analys		(First, Middle, Ma		Maryland
$\geq$	ntal l od o	Be									
2	2 should be filed within 72 hours after dea and Mental Hygiene. Is marked other than "natural", or itema aumatic event, Ita Madical Examinating	2	John Peter Hoffman 19a. Informant's Name/Relationship (		10h Mailin	a Addras			h Doroth	y Barry City or Town, State, Zi <sub>l</sub>	- Codal
McIntyve,	d 2 s th an trau										
g	s 1 and 2 should be filed within 72 h I Health and Mental Hygiene. Item 27 ie marked other than "natur other traumatic event, the Macifiel		Tara McIntyre  20a. Method of Disposition	(daughter)	Place of Dispo cemetery, cren	EVESI	me of	Balti	more,_Ma	ryland 212 c. Location - City or T	own, State
Reltimore	permit. Pages 1 end 2 Department of Health s Important: if item 27 is eny injury or other tra		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐	THORITONAL HOLL STATE			,	/ <sub>2</sub> 10			
=	artme ortan injur		21. Signature of Funeral Service Licer	, 01			rematory			Baltimore,	Maryland
a	permit. Departimportumortumortumortumortumortumortumortum	1	9/20 1 C	1 1 2	Į TV	litch	ell-Wied	efe1d	Funeral	Home, Inc Maryland	01010
			23a. Part1. Enter the disease, or com shock, or heart faiture. List only	plications that caused the dea	ith. Do not ente	er the mo	YOUK RO	ad Ba as cardiac or	respiratory arres	Maryland	ZIZIZ Approximate
			tmmediate Cause (Final	one cause on each line.  CARDIDPULN							Approximate Intervat Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a conse		Ps	RREST				
	Examiner			- CHRONIL C	BSTRUC	TIVE	PULMO	NARY	DISEA	SE	
	S. Sanda	ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse		1100			D( ) = 11.		
	be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events	C							
	be executed icien and burial-transit	EX	resulting in death) Last	Due to (or as a conse	quence of):						
3760	, <u>a</u> × a	cai	(	d							
68	The law requires that the death certification is the law requires that the death certificate has been signed by the attending phyage 2 should be detached for use as the	by Physician/Med	IF FEMALE:								
Box	ath ce	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Ectopic p	regnancy			23d. Date of deliv	,
-	of the dea by the al	sici	1 Yes 2 No	4☐Pregnant at time of 9☐ Unknown	death 5	Other (s	oecify)			Month	Day Year
٥	thet the	P.	Part II. Other significant conditions c		dai i at-				CO. Didah		
Division of Vital Becords P.O.	ires ti signe	ģ	Part II. Other signmeant conditions c	ontributing to death but not re	sulling in the ur	ngeriying	ause given in Par	τι.		cco use contribute to t	./
Š	w requir been si should	Completed							1 192	2010 30 710	Dably 4 ENDIKIOWII
9	e law has b	d d							24a. Was an autopsy	prior to co	opsy findings available empletion of cause of
-	: The cete ha	Ö							performe 1 ☐ Yes 2 ∑	d? death? No 1 ☐ Yes	2 🗆 No
Ž.	Attending Physicien: 1 r death. r death. sctor: After this certificel by the funeral director, p	Be	25. Was case referred to medical examiner?	Hospital:				ce of Death	Check only one		
<b>4</b>	Phys this	2	1 ☐ Yes 2 ⊠No 27. Manner of Death	28a. Date of Injury	ER/Outpatien					ce 6 ☐Other (Special	(y)
2	ding After funer	ig E	Natural 5 ☐ Pending	(Month, Day Year)	28b. Time of Injury	м	28c. Injury at Work? 1 ☐ Yes 2 [		8d. Describe how	injury occurred	
S	death death stor: / the	Ical	3 ☐ Suicide 6 ☐ Could not be		lome farm stre				Of Location (Street	et and Number or Run	of Pouts Mumber
<u>:</u>	i or Attend after death Director: ,	Certification:	4 ☐ Homicide determined	building, etc. (Spec	ify)	eet, factor	у, опісе	-	City or Town, S	State)	ar noute Number,
-	To the Hospital or Attendi within 24 hours after death. To the Euneral Director: a completely filled in by the fi		29a. Certifier Certifying Ph	ysician: To the best of my kn	owledne death	1 OCCUPTED	at the time date :	and place or	nd due to the carr	se(s) and manner as	tated
	24 h	Medical	(Crieck only 2 Medical Examone)	iner. On the basis of examin and manner stated.	ation and/or inv	estigation	i, in my opinion, de	eath occurre	d at the time, date	and place, and due t	o the cause(s)
_	orthin orth	₩.	29b. Signature and title of centrer	<del></del>		29	c. License number	r	29d	. Date signed (Month,	Day, Year)
	F 5 F 0		1 min				D006195	9	A	PRIL 05, 20	006
	nT		30. N ma and press of person who	completed cause of death (Ite	m 23a) (Tvne i					•	
1	8		AMAN SIBAL, MD. SIN	VAL HOSPITAL OF B	MTIMORE	E. Zho	W BELVE	DERE .	AVE, BALT	IMORE, MD	21215
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign			-				
	Registr	ar	APR 1 9 2008	Man A	Mars	28					

			For State Registrar	State of	f Marylar	-	artment of H		nd Mental H	ygiene Reg. No.	16 1	11	48
			Decedent's Name (First, Middle)	Last)				****	2. Date of E	Death		Time of	Death
	Physici /Medio		Catherine	Me1	.e				Month April	9, 2006	Year 7:	30	A M
	Examir		4a. Facility Name (If not institution,	give street and num	nber)		4b. City, Town, or	Location of	Death	4c. County			
			5925 Heritage R				East New				hester		
	Funeral			6. Sex 1 ☐ M 2 🖫 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Month, L		<ol> <li>Birthplace Country)</li> </ol>	(State o	r Foreign
	Director		152-18-4934 Usual Residence of Decedent		77	113.			Sept	26, 1928		NJ_	
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation	-			10d. I	nside Ci	ty Limits
	a-f e	ţ	MD Dorch	ester	Fac	st New	Market				1	I ☐ Yes	2 📉 No
	or 28	Director	10e. Street and Number			IL III W	10f. Zip Code			10g. Citizen of	What Country?		
	23e	ie i	5925 Heritage R	oad			2163	31		U	SA		
	er de	une	11. Marital Status	12. Was Dece Armed For	rces?	I.S. 13.	Was Decedent of Hi f Yes, specify Cuba	spanic Origi n, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	lo- 14. Rad Blad	e - American Ir ck, White, etc.	ndian,	
36	rs aft	λF	1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	ed 1 ☐ Yes If Yes, Give Year or Da	2₽ No e ∡		1 ☐ Yes 2 No	Specify:		Specif	Whit	0	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f ehow the Medical Exam intrinal te routified at	Completed by Funeral	15. Decedent'			16a. Dece	dent's Usual Occupa	ation		16b. Kind of B			
215	hin 7.	pie	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-	-4or 5+)	(GIVB	kind of work done on DO NOT use retired	tu <i>rina</i> most (	of working			,	
2	giene Tth	mo.	12	College (1	-401 34)	Sa	les Assoc	iate		Re	etail		
ם	d oth	Be (	17. Father's Name (First, Middle, L	ast)					's Name (First, Middi	e, Maiden Suman	19)		
<u>X</u>	Ment Brke	2	Unk					Unk					
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f ehow any injury or other traumatic event, the Medical Experiment must be cultilled at angle.		19a. Informant's Name/Relationsh Art Mele	ip <i>(Туре, Print)</i> Son		19b. Mailir 131	ng Address <i>(Str</i> eet a	nd Number	or Rural Route Num Catonsvil	ber, City or Town,	State, Zip Cod 21228	(e)	
e,	1 and Health		20a. Method of Disposition		20h F		sition (Name of	7	Date	20c. Location -		Ctata	
Baltimore,	nt of or or or or or or or or or or or or or		1XXBurial 2 ☐ Cremation		State	cemetery, cren	natory or other place le Vetera		-13-06	Crownsv			
Ħ	artme ortan injury	1	4 Donation 5 Other (Sp 21. Sign of Offuneral Sensica L		7					Olowiis v.	LIIE, II		
B	Depa Impo eny i		K Gregory F		MO1148		ink Ther		me, P.A. W, Glen Bı	irnio M	2106	1	
		`,	23a. Part1. Enter the disease, or of shock, or heart failure. List of	controlligations that ca	aused the deat						App	roximate	•
	Pnysician		Immediate Cause (Final disease or condition	my one cause on ea	ILI	in a	cance					rval Betweet and D	
	/Medical		resulting in death)	Due to (	or as a conseq	juence of	curico	1			14	cu	<u>r</u>
	Examiner		Sequentially list conditions.	b									
7	ait sit	line	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Unsease or injury	Due to (d	or as a conseq	uence of):							
	and and Il-tran	Examiner	that initiated events resulting in death) Last	c	or as a conseq	mence of):							
760,	death certificate be executed e attending physician and id for use as the burial-transit	icalE				,							
687	ificate g phy: as the	8		0									
Вох	leath certific attending p	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outo	come of pregna		ie			23d. Dat	e of delivery		
	deat ne att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No		ant at time of d		Ectopic pregnancy   Other (s <i>pecify)</i>			Мо	nth Day	Y	'ear
о. О	at the de d by the etached	Phy	9 Unknown	1									
Ś	The law requires that the ste has been signed by thi page 2 should be detache	þ	Part II. Other significant condition	s contributing to de	ath but not res	ulting in the ur	nderlying cause give	n in Part I.		tobacco use cont			
Ö	v require been sig should b	eted	···	7					_   '-	Yes 2□No	3 Probably	4 🗇	nknown
Records,	: The law cete has t page 2 s	Completed							24a. Wa	opsy	Nere autopsy fi prior to complet death?	indings a tion of ca	ivailable iuse of
			or W.	-pro-					1 Yes	2 No 1	Yes 2	No	
5	siclan: certific irector,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ▼ No	Hospital:		50/0 · · · · ·	Othe	_	of Death   Check only				
ō	Attending Physician: r death. ector: After this certific by the funeral director.	٦: <u>٦</u>	27. Manyfer of Death	28a. Date o	f Injury	ER/Outpatien 28b. Time of	28c. Injury Work	INUIS	sing Home 5 V es	how injury occurr			
0	ttending I death. ctor: After y the funer	atio	1 Vatural 5 ☐ Pending 2 ☐ Accident investiga		n, Day Year)	Injury		? ′es 2.∐No	0				
Division of Vital	er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	288. Place	of Injury - At ho g, etc. (Specif	ome, farm, stre	eet, factory, office		28f. Location	(Street and Numb	er or Rural Rou	ite Numb	oer,
	itelo irs aft rel Di led in	Cer		lo de la companya della companya del									
	To the Hospitel or Attentwithin 24 hours after death To the Funerel Director: completely filled in by the	ical	(Check only 2 Medical E	xaminer: On the ba:	sis of examina	wledge, death tion and/or inv	occurred at the tim	e, date and inion, death	place, and due to the occurred at the time	cause(s) and ma	nner as stated.	cause(s)	
	To the within 2 To the complet	Medical	one) 29b. Signature and title of certifier	and mann	er stated.		29c. License			29d. Date signed			
3	8 4 5 4		1 Count	tom -					1				
	1	-	30. Name and address of person w	no completed cause	of death /Item	23a) (Type 1	Print)	(00		170/0			
	l		David Smith.	M.D. 29	406 P	intail	Drive -S	uite.	1 5 , Easlz	n, ms	21601	,	
	Sta	-	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ture	1						
4.	Registr	ar	APR 1 2 2	2006	Singer A		WE !						

			1 - For State Registrar	State of Marylar			lealth and M	lental Hyg	iene	11449
	Physici	an	Decedent's Name (First, Middle, Last	st)				2. Date of Deat Month	h Day Year	3. Time of Death
	/Medi		Gerald E. Mona			<del>,</del>		Apri1	3, 2006	3:00P <sup>™</sup>
2	Examir	ier	4a. Facility Name (If not institution, give				Location of Death		4c. County of Dea	
_			Baltimore Wash  5. Social Security Number 6. S			Glen B	urnie	a Data of Bish	Anne Ar	
	Funeral Director		1	MSM 2□F 79	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 07/28/	1926 9. Bir	thplace (State or Foreign buntry) MD
	rylanc how		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. tnside City Limits
	e Ma	ctoi	MD Anne A	runde1 H	Pasade	ena				1 ☐ Yes 2 ₹ No
	ith th	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Co	puntry?
	ath w		7816 Outing Av			21122			U.S.A.	
36	be filed within 72 hours after death with the Maryland ital Hygiene. dother than "natural", or items 23e or 28e-1 show event, the Madical Examinar must be mutilised at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No		ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: W	nican Indian, e, etc. Thite
215-0036	n 72 hou "natura	Completed	15. Decedent's Ec (Specify only highest gra		16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of work	ing 1	6b. Kind of Business	
212	with lene. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+) 2		ambing	,		Contract	ina
Ö		Be C	17. Father's Name (First, Middle, Last)		110	Imbilig	18. Mother's Name	e (First, Middle, M		ing
<u>a</u>	Mental Mental Irked o	To B	James L. Mona	ghan			Mary E	. Kamme	r	
Maryland	ss 1 and 2 should be of Health and Mental liem 27 is marked ( other traumatic ev		19a. Informant's Name/Relationship (7	Type, Print)	19b. Maili	ng Address (Street a			City or Town, State, 2	Zip Code)
	and 2 ealth in 27 i		Beverly Monagh	an/Wife	7816	Outing	Avenue	, Pasad	lena, MD	21122
<u> </u>			20a. Method of Disposition 1 ☐ Burial 2 <b>E</b> Cremation 3 ☐	20b. F	Place of Dispo	sition (Name of matory or other place	e)   [		Oc. Location - City or	
Ĕ	Pages ment of ant: if its ury or o		4 □ Donation 5 □ Other (Specify	nemovariiom State				7/06 E	Baltimore	, MD
Baltimore,	permit. Page Department i Important: if sny injury or once.		21. Signature of Euneral Service Licen	see					Funeral	
_	00 = 0		The free						dena, MD	21122
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseq	prolic	er the mode of dying	2 A		st,	Approximate Interval Between Onset and Death
3/60,	cate be executed hysician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Final Inserting Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq c. Due to (or as a conseq d						
O. Box 6	the death certific y the ettending p iched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	Ideath 3□	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
T	law requires that as been signed b 2 should be deta	by Pi	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	nderlying cause give	n in Part I.	23e. Did toba	acco use contribute to	the cause of death?
cords	quire an sig uid b		Appelinsion					1 ☐ Yes	2 □ No 3 □ Pro	bably 4 🗷 Inknown
ည သ	awre s bee 2 sho	Completed	Side to Me	With type	1			24a. Was an	24b. Were au	topsy findings available
Ĕ	sician: The law certificate has b lirector, page 2 s	E	Olive Detruc	tive pulsono	10 00	isen		autopsy	ed? death?	ompletion of cause of
VII	ian: rtifica ctor.	Bec	25. Was case referred to medical examiner?		1		26. Place of Death	1 ☐ Yes 2		2 No
>	Physician: rthis certific ral director,	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 🗵	ER/Outpatien	t 3□ DOA Othe	_		ce 6 Other (Spec	ufy)
	After fune	atlon:	27. Manner of Death  1   Natural  2   Accident  Accident  Accident  Accident	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe how		
2	ital or Att rs efter de ai Directi led in by t	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stro	eet, factory, office	2	28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or Attending within 24 hours efter death.  To the Funeral Director: After completely filled in by the fune	ledical	one)	rsician: To the best of my kno iner: On the basis of examinal and manner stated.	tion and/or inv	estigation, in my op	inion, death occurre	ed at the time, dat	e and place, and due	to the cause(s)
ŀ	To with	×	29b. Signature and title of certifier	y MA		29c. License	number 5521	290 A	d. Date signed (Month Pril 3, 2e wite 208	Day, Year)
	6		30. Name and address of person who co	or leted cause of death (Item	23a) (Type,	Print) 325 H	ospital D	rive S	nite 208	
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signa	tuse A	Shen 6	conte, 1	ND ZIE	061	
	Registra		APR 1 2 20	106 Marian	The same of the sa	Second Second				

## Please Type or Print in Black Indelible Ink

i icasc i y	pe of 1 time in Black machine inc
State of Maryland /	Department of Health and Mental Hygiene

cNamara, Charl	1- For State	State of Maryla		ent of Health an ate of Death	d Mental Hy		. 0000	1 : 1 ==
Physicia	Registrar  1. Decedent's Name (First,	Middle,Last)	00100			Reg. N 2. Date of Death	4000	3. Time of Death
ledical Examin		Frederick 1		4b. City, Town, or	Location of Death	Month Da April 4, 2006	y Year 4c. County of Death	18:30
· ·	University Hospita	al		Baltimore				
Funeral Director	5. Social Security Number 215-28-438		7. Age (In yrs. last birth 75	nday) If Under 1 Yea Months Day		8. Date of Birth (N	Cou	hplace (State or Foreignuntry)  MD
	Usual Residence of Decede	ent				,		
w any	10a. State 10b. Co	unty	10c. City, Town of	or Location				10d. Inside City Limits  1 Yes 2 No
Aaryland 28a-f show 3 at once.	MD An	nne Arunde:	l Pasa	dena 10f. Zip Code		100	Dikings of Mark Onco	
th the Maryland 23a or 28a-f sho notified at once.	<u>e</u>				•		Citizen of What Cour	iti y r
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once	11. Marital Status 1 Never Married 2		edent Ever in U.S.	2112 13. Was Decedent of His If Yes, specify Cubar	panic Origin? (Spe	ecify Yes or No-	S . A . 14. Race - Americ White, etc.	can Indian, Black,
after d al", on ner m	3 Widowed 4	Divorced If Yes, Give Year or Dates:		1 Yes 2 No	specify:		Specify Whi	te
hours afte 'natural'', Examiner	45 December Education	(Specify only highest grad	e completed) 16a. E	ecedent's Usual Occupat	tion (Give kind of w	ork done 16	b. Kind of Business/I	
36 n 72 h nan "1	Elementary/Secondary (in 12 17. Father's Name (First, M	0-12) College (1-	-4 or 5+)	most of working life. DO N	IOT use retired)			
5-0036 iled within 7 Hygiene. I other than the Medica	12 17. Father's Name (First, M	liddle Last)	Ma	chinist	18 Mother's Name	(First, Middle, Maid	Manufact	uring
21215-0036 Uld be filed within 72 Mental Hygiene. marked other than '	ப் Daniel Mo				Helen		en damane)	
D 21215-00; should be filed within and Mental Hygiene 7 is marked other it natic event, the Med	2 19a. Informant's Name/Rela		19b	. Mailing Address (Stree	et and Number or R	Rural Route Number	, City or Town, State	. Zip Code) 2 1 1 2 2
and 2 should and N tem 27 is n traumatic		rs / Daught		989 Popla				
ore, ML s   and 2 s of Health a If item 27 her traum	20a. Method of Disposition 1 X Burial 2 Crer	_	20b. Place of	f Disposition (Name of cer ory or other place)		Date 20	c. Location - City or	Town, State
Baltimore, permit. Pages   ar pepartment of Hec Important: If ite	4 Donation 5 Oth		an oldio	terans Ce	m 04/	10/06	Crownsvi	lle, MD
Baltimo permit. Page Department of Important: injury or ott	21. Signature of Funeral Se			22. Name and Address	of Facility G.	J.Gonce	Funeral	Home, PA
	mil	Ta	-	169 Rivi			-	
Physician /Medical	23a. Part I. Enter the disear		used the death. Do not	t enter the mode of dying,	such as cardiac or	respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
Examiner	Immediate Cause (Final di or condition resulting in de	- A1- X	y artery diss consequence of):	section				Death
/		h Cardiac	catheterizat	ion				
	Sequentially list conditions if any, leading to immediate	e Due to (or as a	consequence of):	2011				
	if any, leading to immediate cause. Enter Underlying C (Disease or injury that initial events resulting in death)	ated C.	consequence of):					
uted id ansit		d						
<b>60,</b> ate be executed hysician and e burial - transit	X UNPENDED	AMENDED	item#23a-b,PI	I,27,28a-f,per	ME,g855,5/1	12/06 TT		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	UNPENDED  IF FEMALE: 23b. Was decedent pregnar past 12 months?  1 Yes 2 No 9 Part II. Other significant c	nt in the 1 Live bi	ant at time of death	Fetal death 3	Ectopic pregna		23d. Date of delivery Month E	) Day Year
SOX Jeath e attel for u	1 Yes 2 No 9	Unknown g Unkno	3	Other (Specify)				
O. E at the o		onditions contributing to	death but not resulting	in the underlying cause (	given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
, P. res that signed be de	Hypertensive a	therosclerotic	cardiovascula	r disease		1 Yes 2	No 3 Prob	ably 4 🗸 Unknown
rds requi	A Hypertensive a					24a. Was an autopsy		topsy findings available ompletion of cause of
ecol ne law te has	di.					performed		
Vital Recognized Recognized With the certificate I director, page				26.Place	of Death (Check of			2
Vita vysicia vysicia vysicia vysicia	© 25 Was case referred to m examiner? O 1 ✓ Yes 2 No	Hospital: 1 🗸 Ir	npatient 2 ER/Ou	utpatient 3 DOA	Other Nursing	g Home 5 Res	sidence 6 Other	:
ing Ph After After	27. Manner of Death	28a. Date of (Month,	of Injury 28b. T	ime of Injury 28c. Inju	ry at Work?	28d. Describe how	injury occurred CO	ronary artery
ion trendi death. rtor: / the f	Natural 5 2 X Accident 3 Suicide 6 4 Homicide	Pending Investigation 4/4/20		1 .	Yes 2 X No	injured dur	ing procedur	e
ivis lor A after Direct din b	3 Suicide 6	Could not be	of Injury - At home, fa	rm, street, factory, office b				ral Route Number, City
D sspita hours meral y fille		determined (Specify)	hospital				Baltimore W ter 301 Hosp	
Division of Vital Records To the Hospital or Attending Physician: The law requivathin 24 hours after death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should	(Check only Certify	ing Physician: To the best al Examiner:On the basis of and manner st	f examination and/or in					
	29b. Signature and title of o	ertifier (		29c. Licens			ld Date signed (Moi	nth, Day, Year)
	tan u	ionia-	olle.	O.C.	M.E.	Α	pril 6, 2006	
111	30. Name and address of p			inor 444 D 0	root Dalkins	. MD 04004		
	Patricia Aronica-F		int Medical Exam	mer IIIPenn Si	treet, Baltimore	e, IVID 21201		
Sta Registr	ite 31. Date filed (Month, Day,	4	gietrar's Signature	Societé a				
DHMH 17 Rev 1/20		2 2000	Com St.	IGINAL				
OCAAF 40/0000			JK					

DHMH 17 Rev 1/2001 OCME 10/2003

Magruder, John
Physicia Medical Examin

Funeral Director

Baltimore, MD 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any
injury or other traumatic event, the Medical Examiner must be notified at once

Physician /Medical Examiner Please Type or Print in Black Indelible Ink

	State of Maryland / Department of Figure 1- For State Certificate of E	Health and Mental Hy Death	Reg. No.	1145						
an/	1. Decedent's Name (First, Middle,Last)  John Leroy Magruder Jr.		2. Date of Death  Month Day Year	3. Time of Death 4:56						
ner		City, Town, or Location of Death	April 10, 2006  4c. County of Deat							
		B <b>al</b> timore		N/A						
	5. Social Security Number 6. Sex 213-76-6525 1 M 2 F	8. Date of Birth (MM/DD/YYYY) 9. 8i March 31,1958								
	Usual Residence of Decedent  10a. State		10d. Inside City Limits 1 Yes 2 No							
Be Completed by Funeral Director	10e. Street and Number 1610 May Court	0f. Zip Code 21231	10g, Citizen of What Cou	intry?						
uneral		Decedent of Hispanic Origin? (Sp specify Cuban, Mexican, Puerto		rican Indian, 8lack,						
Ϋ́	3 Widowed 4 Divorced If Yes, Give Year or Dates:	es 2 X No specify:	Specify: Bl							
ed	during	Usual Decupation (Give kind of w	ork done 16b. Kind of 8usiness.	/Industry						
mplet	10th Home	king life. DO NOT use retired) Improvements	Self-em	ployed						
ပိ	17. Father's Name (First, Middle, Last)  John L. Magruder Sr.	(First, Middle, Maiden Surname) 7 Mae Lee								
To B	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2113  Dorothy M. Magruder/ Mother 13706 Jarrettsville Pike Pheonix MD									
	20a. Method of Disposition 20b. Place of Disposition	n (Name of cemetery,	Date 20c. Location - City o							
	1 \( \)\( \)\( \)\( \)\( \)\( \)\( \)\(	ME Ch Cem. 4/1	4/06 Long Gr	een, MD						
		on and Address of Escility	ıtman-Harris Fu	neral Home						
6	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the failure. List only one cause on each line.	O Reisterstow	n Rd Baltimore	MD 21215 Approximate Interval 8 etween Onset and						
	Immediate Cause (Final disease or condition resulting in death)  a. Right Femoral Vein Injury  Due to (or as a consequence of):									
-	Sequentially list conditions, if any, leading to immediate  b. Impalement  Due to (or as a consequence of):									
nine	cause. Enter Underlying Cause (Disease or injury that initiated									
Examine	events resulting in death) Last  Due to (or as a consequence of):  d.									
dical	UNPENDED AMENDED									
Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal	death 3 Ectopic pregna	23d. Date of deliver	ry Day Year						
sici		r (Specify)								
Phy	Part II. Other significant conditions contributing to death but not resulting in the unc	lerlying cause given in Part I.	23e. Did tobacco use contribute to	the cause of death?						
d by			1 Yes 2 V No 3 Pro	obably 4 Unknown						
lete				utopsy findings available completion of cause of						
щ			performed? death?	′es 2 No						
BeC	25. Was case referred to medical	26.Place of Death (Check								
To B	examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other Nursin	g Home 5 Residence 6 🗸 Othe	er; Scene						
tion: 1	27. Manner of Death  1 Natural 5 Pending Province Investigation Apr 10, 2006  28a. Date of Injury FOUND: Day, Year) FOUND: Apr 10, 2006  28b. Time of Injury FOUND: O4:54		28d. Describe how injury occurred Subject impaled on unknown	D <b>bje</b> ct						
Medical Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Rear Ibt		28f. Location (Street and Number or R or Town, State) 718 East Preston Street, Balt							
dical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.									
Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (M	onth, Day, Year)						
	totalles tollers	O.C.M.E.	April 10, 2006							
	30. Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 1	11 Penn Street, Baltimore	e, MD 21201							

**6**5

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

31. Date filed (Month, Day, Year) APR 1 2 2006

3. Registrar's Signature

State Registrar

06-02429	
Martin, Patricia	

### Please Type or Print in Black Indelible Ink

rtin, Patricia		State 1- For State Registrar	of Maryland / I	Department o Certificate o		and I	Mental Hy	_	Reg. <b>N</b> o	20	06	The state of the s
Physici edical Exami		1 Decedent's Name (First, Middle,Last Patricia R. M	,					2. Date of De Month April 9, 2	ath Dav	Year	3.	Time of Death 8:15
		4a. Facility Name (if not institution, give			4b. City, Town,		cation of Death	April 9, 2	40	c. County of Charles	Death	
Funeral Director		5. Social Security Number 6. Se 2 1 3 - 5 8 - 4 9 8 8		In yrs. last birthday)  5 5	If Under 1 Y		f Under 24Hrs. Hours Min.	8. Date of B			Counti	
w any		Usual Residence of Decedent  10a. State 10b. County  Md Charles	10	oc. City, Town or Locat	+	l		109/2	Z =1.5	930	10	yland  Od. Inside City Limits
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show any ratic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 16897 Rock Poi		15546	10f. Zip Code 2 0	e 645				izen of Wha		X Yes 2 No
death with the ritems 23a	Funeral	11. Marital Status 1 Never Married 2 Married	12, Was Decedent Ev Armed Forces? 1 Yes 2	If Y			iic Origin? ( Spe exican, Puerto F		lo-	14. Race - White,		ı Indian, Black,
hours after natural", o Examiner n		15. Decedent's Education (Specify on	If Yes, Give Year or Dates: ly highest grade comple	eted) 16a. Deceder			pec <i>ify:</i> (Give kind of wo	ork done	16b.	Specify: W		
21215-0036 ould be filed within 721 Mental Hygiene. i marked other than "ice event, the Medical E.	Completed by	Elementary/Secondary (0-12)  1 2  17. Father's Name (First, Middle, Last)	College (1-4 or 5+)	most of Distri	working life. DO	urt	,				te d	of Md.
) 21215 hould be file ad Mental Hy is marked o	To Be	William J. Ro 19a. Informant's Name/Relationship (Ty		19b. Mailing	Address (SI			garet	Α.	Wilk		p Code)
nd 2		Alvin E. Marti 20a. Method of Disposition 1 Burial 2 X Cremation 3	_ `	20b. Place of Dispos	Box ition (Name of ner place)	2 cemete	Issue,	Mđ Date		545 Location - C	ity or Tov	vn, State
Baltimore, permit. Pages 1 a Department of He Important: If it in injury or other t		4 Donation 5 Other Specify: 21 Signature of Funeral Service Licens	ee	Bayview (	Cremat ame and Addr	ory ess of F	y 04/	12-20 4 Wil	06 10w	Balt Spri	imo ng	re, Md Rd.
Physician /Medical Examiner		23a. Part I. Enter the disease, or complifailure. List only one cause on ead	cations that caused the	e death. Do not enter th	ne mode of dyir				* K	2177	M d	21222 Approximate Interval Between Onset and Death
	Examiner	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Oue to (or as a conseque to (or a) conseque to (or a) conseque to (or a) conseque to (or a) conseque to (or a) conseque to (or a) conseque to (or a) conseque to (or a) conseque to (or a) conseque to (or a) conseque to (or a) conseque to (or a) conseque to (or a	ience of):							+	
o, e be executed ysician and burial - transit	edical Ex	d.  X UNPENDED	AMENDED item		.g855.5/	10/0	6 TT					
;, P.O. Box 68760, ires that the death certificate by signed by the attending physic be detached for use as the but	≥ .	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1  Yes 2  No 9  Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at time	of pregnancy 2 Fe			Ectopic pregnan	су	230	d. Date of de Month	livery Day	Year
es that the digned by the be detached	þ	Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	nderlying caus	e given	n in Part I.	23e. Did t		_		cause of death?
tal Records, cian: The law requir certificate has been s	Completed							24a. Was auto perfo	psy ormed?	prio dea	r to comp	sy findings available pletion of cause of 2 No
ing Physi After this funeral dir	To Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No  27. Manner of Death 1 ✓ Natural 5 Pending 2 Accident Investigatio	ospital: 1 Inpatient 28a. Date of Injury (Month, Day,Year)	2 ER/Outpatient 28b. Time of Ir	3 DOA	Othe		nly one) Home 5		nce 6 🗸		4
Divisior To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	al Certification:	3 Suicide 6 Could not b determined	280 Place of Injury	- At home, farm, stree				or Town,	State)			Route Number, City
To the within 2 To the complete	Medical	one) 2 Medical Examiner:	On the basis of examina and manner stated.	ation and/or investigati	on, in my opini 29c. Lice	ion, dea	ath occurred at i	the time, date	and pla	ce, and due Date signed	to the ca	
		30. Name and address of person who co Patricia Aronica-Pollak MD		n (Item 23a) dical Examiner			t, Baltimore,	, <b>M</b> D 2120				
St. Regist		31. Date filed (Month, Day, Year) APR 1 2 20	32. Registrar's S	Signature	W.							
HMH 17 Rev 1/20 CME 10/2003	001			ORIGINAL								

		-	For Stete Registrar	State	of Marylar	nd / Depa		of He	alth a		ntal Hy	giene	06	11,53	
			Registrar     Decedent's Name (First, Midd	fle, Last)		00.	rimouto	0, 0	Catif	2	Date of Dea			3. Time of Death	
	Physicia		Harry Earl	Nichols						A	Month pril	$\overset{Day}{11}$	2006	2:00 A	А
	/Medic Examin		4a. Facility Name (If not institution	on, give street and i	number)		4b. City, To	wn, or Lo	ocation of		<u> </u>		ounty of Deat		
			2119 Craig La	ine			Edgev					Hai	rford		
	Funeral		5. Social Security Number	6. Sex 1 ★ M 2 ☐ F	7. Age (In yrs.	. last birthday) Yrs.	Months [		f Under 2 Hours	Min.	(Month, Da	y, Year)	9. Birt	hplace (State or Foreig untry)	חן
	Director		542-40-6619 Usual Residence of Decedent	- A.	67	115.				M	ar. 21	, 193	39 Nev	v York	
	/land		10a. State 10b. Count	у	10c. C	ity, Town or Lo	ocation							10d. Inside City Limit	s
	Many a-f sh iffed	to	Maryland Harfo	ord	Ed	gewood								1 ☐ Yes 2X☐ N	0
	or 28.	Director	10e. Street and Number				10f. Zip C	ode				10g. Citize	on of What Co	ountry?	
	ath wi		2119 Craig La					040				USZ			
	er de	Funerai	11. Marital Status	Armed	ecedent Ever in U Forces?	J.S.   13.	Was Deceder If Yes, specify	nt of Hisp Cuban,	anic Orig Mexican	in? (Specif , Puerto Ric	y Yes or No can, etc.)	-   14	I. Race - Ame Black, Whit		
36	rs aft	by F	1 ☐ Never Married 2 ☐ Ma 3 ☐ Widowed 4 反 Divorce	irried 1 154 19 If Yes, Id Year o	s 2 No Give Dates:		1 ☐ Yes 25	No .	Specify:			s	Specify:	Mite	
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28a-f show tha Madical Examination institution		15. Decede	int's Education			dent's Usual (			- 6 di		16b. Kind	d of Business/		
215	thin 7. 9. 9n "n Medi	pie	(Specify only high Elementary/Secondary (0-12)	est grade complete College	a (1-4or 5+)	life.	kind of work DO NOT use	retired)	ring most	or working					
2	e filed within at Hygiene. I other then '	Completed	12		· · · · · · · · · · · · · · · · · · ·	Tru	ck Dri							n Company	
ind	be fill	Be	17. Father's Name (First, Middle		_						First, Middle,		umame)		
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If itam 27 is marked other than "natural", or Itams 23s or 28s-f show or other traumatic avent, the Medical Express. It is the middled at or other traumatic avent.	၉	Robert Harry 19a, Informant's Name/Relation		5	19h Maili	ng Address /			Bel.		elley	Town, State, 2	Zip Code)	
Z	d 2 sho th and ty is m traum		Curtis Nicho				-						nd 2100		
	Health tam 27 other tr		20a. Method of Disposition		20b.	Place of Dispo cemetery, cre				Dat			ation - City or		
MO M	it. Pages rtment of rtant: If it njury or o		1 ☐ Burial 2 反 Cremation 4 ☐ Donation 5 ☐ Other	a 3 □Removal fro Specify)		11top				1-13-0	06	Tows	on, Mai	cyland	
Baltimore,	그 두 후 근		21. Signature of Funeral Service				2. Name and CCOMAS				-			_	
m	Depar Impos any Ir		Russell Se	5-		1	317 Col	kesbi	ury :	Road.	Abino	don,	Maryla	and 21009	
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that st only one cause o	at caused the dea n each line.	ath. Do not en	ter the mode	of dying,	such as	cardiac or r	espiratory a	rrest,	_	Approximate Interval Between Onset and Death	
	Physician.		fmmediate Cause (Final disease or condition	a. ~	retasta	thic s	small	cel	1 2	ing	cance	2		3 months	4
ı	/Medical Examiner		resulting in death)	Due	to (or as a conse	quence of):				0					
k		<u></u>	Sequentially list conditions,	b. — Due	to (or as a conse	uence of									_
W	rted I Insit	Examiner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	<b>~</b>											
,	be executed sician and buriat-transit	Exa	that initiated events resulting in death) Last	c. Due	to (or as a conse	quence of):									
760,	, Y 6	ical		d											
89 3	death certificat e attending phy d for use as th	Physician/Med	IF FEMALE:												
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	1□Liv	outcome of pregr e birth 2 Pet	tal death 3	⊒Ectopic preg					23	d. Date of del Month	livery Day Year	
0	0 60	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Ur	egnant at time of known	death 5	Other (spec	:пу)							
Δ.	The law requires that the de tte has been signed by the a bage 2 should be detached f		Part II. Other significant condi	tions contributing to	death but not re	sulting in the u	underlying cau	ise given	in Part I.		23e. Did t	obacco us	e contribute to	the cause of death?	
Records,	uires r sign lid be	d by									1 🖭	Yes 2	No 3□P	robably 4 Unknow	/n
00	w requir s been si should	lete									24a. Was			utopsy findings availab	
Re	The lav	Completed										psy ormed? 2 ፟ <b>X</b> No	prior to death?	completion of cause of 2 X No	
Vital		a	25. Was case referred to medic	cal				_ 2	26. Place	of Death (	Check only o				
of V	di S	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1	□Inpatient 2			AND DEC. N	#   140	rsing Home	5 Mesi	dence 6	Other (Spe	city)	
n o			27. Manner of Death 1   Natural 5 □ Pend	/4.	ite of Injury Ionth, Day Year)	28b. Time of Injury		. Injury a Work?			d. Describe	how injury	occurred		
Sio	Attendi death. ctor: A y the fu	cati	2 Accident inves	d not be	nee of Injury. At I	homo form of	M		s 2 🗆 l	No 28	f Location /	Street and	Number or R	ural Route Number,	_
Division	or Attend after death Director: /	Certification:	4 Homicide dete	mined 286. Pi	ace of Injury - At I ilding, etc. (Spec	nome, rami, si cify)	reet, factory,	опісе		20	City or To		IVUINDEI OI III	ura: noute vumber,	
_	e Hospital 24 hours a B Funaral etely filled		29a. Certifier 1 Certify	ring Physician: To	the best of my kr	nowledge, dea	th occurred at	the time,	, date an	d place, an	d due to the	cause(s) a	ind manner as	s stated.	
	To the Hospital or Attending within 24 hours after death.  To tha Funaral Director: Afte completely filled in by the fune	Medical		of Examiner: On the											
	To the I within 2 To the I complet	M	29b. Signature and title of certif	ier		4		License r					signed (Mont		
			D. X	llasal		M-		45						2006	
	140,		30. Name and address of person	on who completed o	ause of death (fte	em 23a) (Type	Print)	ocl :	2000	d. I	Bela	uv	UDS	10161	
	1 ,		S SIVASAI		2. Registrar's Sign		,								-
	Sta Regist			2006	<i>A</i>		elle s								
DH	MH 17 Rev 1/2		Hrk 1 Z	CHID AND	CARL FO	17									

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** JACKLYN POTTER 6:10 PM 04 10 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Montgomery Silver Spring
If Under 1 Year I Under 24-Ars. Holy Cross Hospital

5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Min 1□M 20 F (ris.) 224-54-4624 62 Worth Carolina Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours efter death with the Maryland 10a. State 10b. County 10c. City, Town or Location rthan "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Silver Spring Montgomery MD Completed by Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 2204 Richland USA 20910 lace 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Education 12 Teacher 5+ 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be lite Department of Health and Mental Hy Important: if Item 27 is marked oth any linjury or other traumatic event spage. 17. Father's Name (First, Middle, Last) Unknown Jack Heminway Yotter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marchant Wentworth/husband 903 Hamlin St. NE, Washington, D.C. 20017 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crematory 4-12-06 Beltsville, MD 22. Name and Address of Facility Rapp Funeral Tremation Services 21. Signature of Funeral Service Licensee 933 Gist Ave, Silverspring MD 20910 MO1358 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiopulmonary Arrest /Medical Due to (or as a consequence of) Examiner Anoxic Encephalonathy
Dua to for as a sunship ence of): Sequentially list conditions, if dry, leading to animediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Panhypopituitarism Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 █ No 3 Ectopic pregnancy Month Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probabiy 4 ∰Unknown 1 ∏ Yes 2 ∏ No cete has been signification control co 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral: 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) allke 04/10/06 D0064100

12

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)
APR 1 2 2006

Dr. SMITHA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BHKKAT



**ORIGINAL** 

1500 Forest Glen Rd

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of Hertificate of L			ene No.U 0 6	1455
	with	Ž.	1. Decedent's Name (First, Middle, Las	)				2. Date of Death		3. Time of Death
	Physici /Medic		DONALD WIL	SON	PHILLIPS	5		April	7, 2006	5:00 AM
	Examin		4a. Facility Name (If not institution, give				Location of Death	1	4c. County of Dea	ith
			McCready Memorial	Hospital			risfield		Somer	set
- 4	Funeral Director		215-38-0300	X 7. Ag	e (In yrs. last birthday 66 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, October 5,	year) 9. Bij 1939 Mar	thplace (State or Foreign ountry) Yland
	and *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	eho	ŏ			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		61 7 7			1 ☐ Yes 2X No
	28a-1	Director	Maryland Somer  10e. Street and Number	<u>set</u>		10f. Zip Code	sfield	10	g. Citizen of What C	ountry?
	with ta or		3357 Sackertown Ro	200		1000 2400	21817		US	
	leath	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13	Was Decedent of Hi		pecify Yes or No-	14. Race - Am	
21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "natural", or Items 23s or 28s-f show aumatic event, the Medical Exam ar must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1XXVes 2 ☐ I If Yes, Give Year or Dates:	№ 1957- 1968	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	n, Mexican, Puert Specify:	o Rican, etc.)	Black, Whi	te, etc. White
ð	2 ho	Completed	15. Decedent's Ed		16a. Dec	edent's Usual Occupa	ation	fring 1	6b. Kind of Business	Industry
2	hin 7	pie	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	life.	e kind of work done of DO NOT use retired	)  )	KIIIG	Petroleu	m Products
7	or th	Con	12			Painter				
p	be file ital Hy id oth	Be (	17. Father's Name (First, Middle, Last)					ne (First, Middle, M.	aiden Sumame)	
<u>X</u>	should tund Ment	2	Wilson A. Phillip	S			Rosalie	Wilson		
a	and and ls m		19a. Informant's Name/Relationship (T	rpe, Print)		ling Address (Street a				
~	and ealth m 27 her tr	1	Dottie Phillips (	<i>N</i> ife)		Sackerto	wn Road ·			
Baltimore, Maryland	permit. Pages 1 and 2 should Department of Health and Mer Important: If Item 27 is marke eny injury or other traumatic ance.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cri	ematory or other plac	θ)	Date 2	0c. Location - City o	r lown, State
<u>=</u>	rment tant:		4 □Donation 5 □Other (Specify,	)	Asbury C		4/9		risfield,	Maryland
32	Departiment Depart		21. Signatur Punt S ryics Chens	99		radshav				
_	00 = 04			dshaw, Jr		06 W. Mai				
			23a. Part1. Enter the disease, or composhock, or heart failure. List only of	ications that caused ne cause on each li	the death. Do not en	nter the mode of dying	g, such as cardiad	or respiratory arres	st,	Approximate Interval Between Onset and Death
b.	Physician		Immediate Cause (Final disease or condition	a 52	noll a	ell Cu	ny CA	ween		21 montes
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):		0		·	
			Sequentially list conditions	b						
4	sit s	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
la	and I-tran	хап	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
8760,	cate be executed physician and the burial-transit	a E		220 10 (21 22	a 05.100qu0.100 0.7.					
87		dicai		d.						
9 X	ding ding se as	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy				22d Data of de	liver
Вох	atten for u	ian	in the past 12 months?		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of de Month	Day Year
o.	he de	yslc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	time or death 5					
۵.	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Completed by Physician/Me	Part II. Other significant conditions co	ntributing to death b	eut not resulting in the	underlying cause give	en in Part I.	23e. Did toba	acco use contribute	o the cause of death?
ds	uires sign d be	d b	COPD					1 Yes	2 No 3 F	robably 4 Unknown
Division of Vital Records,	w require been si should I	ete	( 00 . MA 0	121to		8-28-		24a. Was an	24h Wara 2	utopsy findings available
Re	ne lav n has ge 2	mp	COLCONONS	1.1200	oug si	30188		autopsy	prior to	completion of cause of
a	ician: The lav certificate has rector, page 2	e Co	OF Man anno referred to medical				75.052	1 ☐ Yes 2	No 1□Ye	s 2 No
⋚	sicia certi irecto	∞ .	25. Was case referred to medical examiner?	Hospital:	2	Othe	200	th Check only one		
ō	Phys r this ral di	1: To	27. Manner of Death	28a. Date of Inju	ıry 28b. Time	IN SUIDON	4 U Nursing H	28d. Describe how	ce 6 Other (Spa	ecity)
on	ding h. Afte fune	tlor	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year) Injury		c? Yes 2 □ No			
<u>isi</u>	Atten dea ctor ctor	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Inj	ury - At home, farm, s	treet, factory, office			et and Number or F	Rural Route Number,
á	after after Dire	Certification;	4  Homicide	building, et	c. (Specify)			City or Town,	State)	
	To the Hospital or Attending Physician: The I within 2 Hours after death. To the Funeral Director: After this certificate he cimpletely filled in by the funeral director, page		29a. Certifier 1 - Certifying Phy	sician: To the best	of my knowledge, dea	th occurred at the tim	ne, date and place	, and due to the car	use(s) and manner a	s stated.
	n 24 n 24 ne Fu	Medical	(Check only 2   Medical Exam one)	iner: On the basis of and manner sta	f examination and/or i ated.	nvestigation, in my or	oinion, death occu	rred at the time, da	e and place, and du	e to the cause(s)
	Withii To tt	ž	29b. Signature and title of certifier	.A		29c. License	number	29	d. Date signed (Mon	th, Day, Year)
}	,		) ( Pals	-MD		1	-398	13	4/71	06
	1		30. Name and address of person who o	ompleted cause of d	leath (Item 23a) (Type	Print) DO	. 1 . 5		-1 2	0
	リ		MARKINS	140	2011	esse 1	legton	113, C	145 Field	on on
130	Sta		31. Date filed (Month, Day, Year)	188	ar's Signature	W)				21817
3-	Registr	ar	APR 1 2 200	) Aller	- 17					

				i lease	State of Marylar				_
				For State Registrar	State of Marytai		ate of Death	Reg. N	deall dub
	ē,	A DE		Decedent's Name (First, Middle, Las	(1)	_ 1		2. Date of Death	3. Time of Death
-		Physici /Medic		THELMA	PATI	ON		April 1	2006 925 A M
		Examin		4a. Facility Name (If not institution, give	. 10	4b. Cit	ty, Town, or Location of Dea	ith 4	c. County of Death
	434		198		ok Avenue	00	Oltimore der 1 Year   If Under 24 Hrs	S O Date of Birth	NA Bishalass (State on Fourier
	*	Funeral Director		5. Social Security Number 6. Sr 219-40-7829	ex 7. Age (In yrs.	Yrs. Month			9. Birthplace (State or Foreign Country) 35 South Carolina
	1.2	W-		Usual Residence of Decedent	70			7 20 77.	
		anylan show	_	10a. State 10b. County		ty, Town or Location	0- 10-		10d. Inside City Limits 1    Yes 2 □ No
		88a-1	ecto	Maryland NII	7 10	ALTIMO	RE CITY	10- 6	Citizen of What Country?
10		with t	٥	10e. Street and Number  2725 WALBROD	K AVE, APT.	- /	21216	/ J	S.A.
17		death with the Maryland ma 23a or 28a-f ehow rmat be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in L Armed Forces?		cedent of Hispanic Origin? ( pecify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - American Indian,
0	9	or Its	/ Fur	1 Never Married 2 Married	1 ☐ Yes 2 🗷 No If Yes, Give		pecify Cuban, Mexican, Pue 2 <b>™</b> No Specify:	nto rican, etc.)	Black, White, etc.  Specify: 72 / 00 /
	003	within 72 hours after ene. than "natural", or Ite	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:			101	BEACK
)	15	n 72 in 72 in at	Completed	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Decedent's Us (Give kınd of v life. DO NOT	sual Occupation work done during most of wi Tuse retired)	orking 166.	Kind of Business/Industry
2	212	d with giene.	оше	Elementary/Secondary (0-12)	College (1-4or 5+)	FACTOI	RY WOR		NA SURF CHEMICALS
12	bu	e filed at Hyg lothe	Bec	17. Father's Name (First, Middle, Last)		-0 - 1)0		ame (First, Middle, Maide	- 4
12	ylaı	should bund Mentals marked	To	ALONZO_		TRONG			MCULLSON
1	Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23a or 28a-1 show any injury or other traumatic event. The Madical Examinar must be notified at once.	8	19a. Informant's Name/Relationship (			ess (Street and Number or F	·	
		1 and Healti em 2		20a. Method of Disposition		Place of Disposition (A cemetery, crematory of			LOCATION - City or Town, State
	Baltimore,	ages ant of nt: If it	ļ i	1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	cemetery, crematory o	or other place)	-19-2006 BA	LTIMORE, MARYLAND
	altir	mit. Fortant		21. Signature of Funeral Service Licen		22. Name	and Address of Facility 2	40 N. FUITO	N Avenue 21217
	ä	Departing Departing Support		rich 1	). William	no Josep	h H. Brown J	Funeral t	Home Bultimore MD.
				23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea one cause on each line.	th. Do not enter the m	node of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between Onset and Death
	Y 200	Physician		Immediate Cause (Final disease or condition	a Metast	atick	sicast (	ance	1
		/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):			
	4		e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence of).			
1	H	outed and a	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c.				
	0	e exection and and and and and and and and and an		resulting in death) Last	Due to (or as a conse	quence of):			
	8760	ate be shysicia the bur	dical		. d				
	Вох 68	ding p	Physician/Med	IF FEMALE:	23c. ff yes, outcome of pregn	ancv			23d. Date of delivery
	Bo	atten after of for u	clan	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live birth 2 ☐ Fet 4 ☐ Pregnant at time of	al death 3 □Ectopic	pregnancy (specify)		Month Day Year
	P.O.	t the c by the achec	hysl	9 Unknown	9□ Unknown				
		The law requires that the death certificate be executed te has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions of	ontributing to death but not re	sulting in the underlying	g cause given in Part I.		o use contribute to the cause of death?
	ord	equir sen si tould						1 Tes	2 No 3 Probably 4 Unknown
	ec	2 5 8	Completed					24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
	E H							performed	death? No 1 Yes 2 No
	Vit.	Phyaician: The faw this certificate has t ral director, page 2 s	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	☐ER/Outpatient 3☐	Othor	eath (Check only one)	0 COh (C
	of	> 0 0	-	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury at Work?	Home 5 Residence 28d. Describe how in	
	ion	ath. r: Aft	atlo	i Natural 5 Pending 2 Accident investigation		Injury M	1 Yes 2 No		
	Division of Vital Records,	r Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At the building, etc. (Spec	nome, farm, street, fact	lory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
	D	pital c urs at aral D illed ir		One Contiller And Asset To	urajajam To da ka ka ka ka ka	audadaa di sii			(2)
		To the Hospital or Attending Ph within 24 hours after death.  To the Funeral Director: After thi completely filled in by the funeral	edical	29a. Certifier 1 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my kn niner: On the basis of examin and manner stated.	owledge, death occurr ation and/or investigati	ed at the time, date and plac- ion, in my opinion, death occ	ce, and due to the cause curred at the time, date a	(s) and manner as stated.  Ind place, and due to the cause(s)
		To the within Fo the comple	Me	29b. Signature and title of certifier		-	29c. License number	29d. I	Date signed (Month, Day, Year)
		, 24 0		Kallan	n / Cour	ul	036148		1-11-06
		2		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)		7((	CLP 11
		J		KATHERINETU	CH July	W,017	ouglaw / 2	Doverne	21/Dalture (1)
		Sta Regist		31. Date file PRINT Dag Y2006	22 Ragistrar's	aidi	U		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav PILLSBURY Year Month **Physician** 0547 AM DEBBIE 2006 APRIL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JOHNS HOPKINS HOSPITAL BALTIMORE CITY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Months | Days | Hours | Min. | May 12, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Funeral 1□M 2₹F 1954 Delaware 222-32-2300 51 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Item 27 is marked other than "natural", or items 23e or 28a-1 ehow other traumatic event, the Medical Examinar must be nutified at 1 ☐ Yes 2 No Directo Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 609 Mulberry Lane 21040 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Parent Visitor Education 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be <sup>o</sup> Wayne Delbert. Bennett Elizabeth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 si ment of Health an ant: If Item 27 Is r Melvin Robert Pillsbury - Husband 609 Mulberry Lane, Edgewood, Maryland 21040 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or Delaware Vet. Mem. Cem. 4/13/06 Bear, Delaware 21. Fig a ture of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 19 mast 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE LIVER FAILURE **Physician** 24 HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 6 MONTHS ACUTE MYELOGENOUS LEUKEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed Due to (or as a consequence of) Box 68760, Physiclan/Medical as the attending IF FEMALE 1Se 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day Year ō 4☐ Pregnant at time of death 5 ☐ Other (specify) P.0. been signed by the should be detached 9 Unknown 9 Hünknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 124 hours after death.

Funeral Director: A death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. To the the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0 RES-000 APRIL 9, 2006 Culnum Salut Males, MEDICAL DOCTOR 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D MALIK, 600 NORTH WOLFF STREET, BALTIMORE, MARYLAND 21287 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

DHMH 17 Rev 1/2001

APR 1 2 2006

i
ox 68760,
P.O. Box
Records,
Vital
sion of
$\leq$

			State of Maryla	nd / Depa		Health and M	lental Hygie	•	1458
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  EDWARD I	PAU	IL		2. Date of Death Month	Day Year	3. Time of Death
) 	Examir Funeral			i. last birthday)	Baltim If Under 1 Year		8. Date of Birth	4c. County of Death	N/A  nplace (State or Foreign untry)
¥5,50	Director		205-28-5330	8 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month Day) 0CT.2,19	37	MD
ID-UUSO n 72 hours after death with the Maryland n 72 hours after death with the Maryland "natural", or items 23e or 28e-f ahow edical Examiner must be notified at		Director	10a. State 10b. County 10c. C  MD CARROLL  10e. Street and Number	,	MINSTER  10f. Zip Code		100	. Citizen of What Co	10d. Inside City Limits 1 ☐ Yes 2 📉 No
		Funeral Dir	1830 S. PLEASANT VALLEY ROAD  11 Marital Status  12. Was Decedent Ever in U	J.S. 13.		21158 Hispanic Origin? (Spian, Mexican, Puerto		14. Race - Amer	USA rican Indian,
0000	72 hours after natural, or ite	þ	Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  1 Never Married 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		Black, White	WHITE
-61717	a filed within 72 h I Hygiene other than "nati	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  2  College (1-4or 5+)	lite.	dent's Usual Occup kind of work done DO NOT use retire STANT POS	,		b. Kind of Business/l	
/land	D a D .	To Be C	17. Father's Name (First, Middle, Last)  JOSEPH	PAUL		18. Mother's Name	e (First, Middle, Ma	iden Sumame)	LEVY
e, mar	교육도부		19a. Informant's Name/Relationship (Type, Print)  ELAINE PAUL / WIFE  20a. Method of Disposition 20b.	1830	-	ANT VALLE	Y ROAD -		ER, MD 21158
baltimor	permit. Pages 1 and Department of Heali Important: If item 2 any injury or other page.		1 X Burial 2 Cremation 3 Removal from State	Cernetery, crer	matory or other pla	CEM. 04/1	1/2006	REISTERST	OWN, MD
<u>0</u>	Department of the permitted of the permi		Acoth M. Cutth	8	3900 REIS	TERSTOWN	ROAD - PI	N & BROS. KESVILLE,	
	Physician		23a. Part1. Enter the disease, or complications that ceused the deal shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)			ng, such as cardiac o			Approximate Interval Between Onset and Death
	/Medical Examiner	er	Due to (or as a conse	Distre	:55				
,00,	ate be executed sysician and he burial-transit	cai Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consecutive to or as a consecuti		leuman	ia			
	ntificate ing phys a as the		IF FEMALE:						
.O. DOX	To the Hospitel or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnant at time of the past 12 months?  4 Pregnant at time of the pregnant at time at the pregnant a	23d. Date of deli- Month	very Day Year				
cords, r	equires that en signed b ould be deta		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to  1 Yes 2 No 3 Pro						
בים בי	: The law ricete has be page 2 shi	Completed by					24a. Was an autopsy performe	d? death?	topsy findings available ompletion of cause of
<u> </u>	ysician is certifi director	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No Hospital: 1 ☑ npatient 2 □	] ER/Outpatien	nt 3 DOA Ct	26. Place of Death		e 6 □Other (Spec	ufv)
	trending Ph death. tor: After th the funeral	Certification:	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28b. Time of Injury	M 1 □	ry at rk?  Yes 2 □ No	28d. Describe how	injury occurred	
2	spitel or Al ours after o seret Direc filled in by		28e. Place of Injury - At Pulling, etc. (Special Special ify)			City or Town, S			
	thin 24 h	Medical	(Check only one)  2 Madical Examinar: On the basis of examinand manner stated.  29b. Signature and title of certifier	ation and/or inv	vestigation, in my o	opinion, death occurr	ed at the time, date	and place, and due  Date signed (Month	to the cause(s)
	F 3 F 3		I Ruch Promini		Re	9-000		pril 10,2	
	6		30. Name and address of person who completed cause of beath (Ite		Print) Ivedeve	Paul m	0 21210		
1000	Sta Registr		31. Date filed (Month, Day, Year)  APR 1 2 2006		W.				

			, FOI	partment of Health and Nertificate of Death	Mental Hygi	•	1459	
	Physici /Medi Examir	cal	1. Decedent's Name (First, Middle, Last)  Marie K. Rutkowski  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death Baltimore	2. Date of Death Month		3. Time of Death 8:00 A M	
A 200	Funeral Director		9415 Orbitan Court  5. Social Security Number 212-20-7311  Usual Residence of Decedent		8. Date of Birth (Month, Day, )	9. Birthpl	ace (State or Foreign try)  Land	
	e Maryland Se-f show	ctor	10a. State 10b. County 10c. City, Town or Maryland Baltimore	Location  Baltimore		10	0d. Inside City Limits 1 ☐ Yes 2 No	
	th with th	Funeral Director	9415 Orbitan Cowrt	10f. Zip Code 21234	109	g. Citizen of What Coun U.S.A.	try?	
9036	be tiled within 72 hours after death with the Maryland hat Hygiene. Id other than "natural", or items 23a or 28e-f show event, if a Medical Exercitar must be multiled at		11. Marital Status  1 Never Married 2 Married  1 Yes, Give  1 Was Decedent Ever in U.S. Armed Forces?  1 Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto     □ Yes 2(X) No Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e Specify: (W		
21215-0036	tiled within 72 h Hygiene. other than "natu	Completed by	(Specify only highest grade completed) (Gi Elementary/Secondary (0-12) College (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Receiving Clerk			ustry Co •	
Maryland	b d la b	To Be	17. Father's Name (First, Middle, Last) Walter Kowalczyk	18. Mother's Nam  Marianne	e (First, Middle, Ma U Glinou	aiden Sumame) Viecki		
	nd 2 state at trau			iling Address (Street and Number or Rui 5 Orbitan Court, Bo		•	Code)	
Baltimore,	Pages 1 and 3 nent of Health ent: If Item 27 iry or other tr		20a. Method of Disposition 20b. Place of Disposition 1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition cemetery, cl	position (Name of ematory or other place)	Date 20	oc. Location - City or Too arkville. M		
Baltir	permit. Pages 1 as Department of Hea Importent: if Item sny Injury or othe once.			22. Name and Address of Facility Sc. 9705 Belair Rd., I	imunek Fi	uncral Home		
	Physician /Medical Examiner	resulting in death)  Due to (or as a consequence of):						
68760,	ate be executed hysicien and he burial-transit	ical Examiner	Sequentially list nonditions if any, leading to immediate cause. Enter Underthying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):					
P.O. Box 68	The law requires thet the death certifical ate has been signed by the attending phy agge 2 should be detached for use as the	Physician/Med		B⊟Ectopic pregnancy B⊟ Other (specify)		23d. Date of deliver Month	ry Day Year	
	uires thet signed b	þ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the	e cause of death?	
Vital Records,		Completed	Peripheral viscular d	isease	24a. Was an autopsy performs	prior to com	osy findings available apletion of cause of 2 No	
of Vita	Physicien: Th this certilicate al director, pag	To Be	25. Was case referred to medical examiner?  1   Yes   2   No	ent 3 DOA Other: 4 Nursing Ho	h <i>(Check only one)</i> me 5 <b>X</b> esiden	ce 6	)	
sion o	Attending P death. ctor: After t y the funera	ation:	27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)  28b. Time (Month, Day Year)		28d. Describe how	injury occurred		
Division	Hospitel or Attending Physicien: 4 hours after death. Funerel Director: After this certificitied in by the funeral director.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	et and Number or Rural State)	Route Number,	
	To the Hospitel or Atti within 24 hours after de To the Funerel Direct completely filled in by th	edicai	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de control one passis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the cau red at the time, date	se(s) and manner as sta e and place, and due to	ated. the cause(s)	
)	To the within 2 To the complet	Ň	29b. Signature and title of certifier  Purples	29c. License number	) 29c	1. Date signed (Month, E	Day, Year) 2006	
	10		30. Name and a Idress of a rson who appleted cause of death (Ijem 23a) (Type Line) A PECTE MD 6 11 8	RIDGE ROAD T	Baltime	ere, MD.	21237	
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2 2006	redi	-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Henry Francis Rosendalo April 1:05 P 2006 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 13 Silver Hill Court Perry Hall If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Oay, Year, July 8, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 1(XM 2□ F 83 Yrs. Maryland 217-16-6826 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore Perru Hall Maruland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13 Silver Hill Court 21128 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW 11 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Manager Dru Cleaner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) O'Brien Henry Francis Rosendale, Sr. Margaret C. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Silver Hill Court, Perry Hall, MD 21128 Mrs. Dorothy Rosendale (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Joseph Ch. Cem. 4/11/2006 Fullerton. Maryland 22. Name and Address of Facility Schimunek Funeral Homes 21. Signature of Funeral Service Licensee 9705 Belair Rd., Baltimore, MD 21236 mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☑ Nnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 26. Place of Death (Check only one)

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f ehow

ŏ

or iteme 23a

permit. Pages 1 and 2 should be filed within 72 hours after begartment of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or itemeny injury or other traumatic event, the Medical Examines.

Baltimore, Maryland 21215-0036

Director

Completed

other traumatic event, the Medical Examiner must be notified at

Examiner Physician/Medical ģ Completed Be

the attending physicien and hed for use as the burial-transit sete has been signed by the atte page 2 should be detached for To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice

Division of Vital Records, P.O. Box 68760

State

Medical

25. Was case referred to medical 2 No 1 Tes 27. Manner of Death 1 Naturat 2 ☐ Accident 3 Suicide 4 Homicide

29b. Signature and title of certified

(Check only

5 Pending investigation 6 Could not be determined

1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient

Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the

3□ DOA

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

r: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marrier stated.

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

29d, Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of deau (Item 23a) (Type, Print) 7600 Osler Ortve, Towson, MD 21204 Dr. Ayman Akkad,

31. Date filed (Month, Day, Year)

APR 1 2 2006

32. egistrar's Signature

DHMH 17 Rev 1/2001

Registrar

Physicia /Medica Examine

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or Itams 23a or 28a-f show eny injury or other traumatic event, Ira McJical Examinational be notified at once.

Physician /Medical Examiner

anding physician and use as the burial-transit

To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

	Please Type or Print in Black Indelible In	k. Ensure All Copies Are Legible.
For	State of Maryland / Department of	Health and Mental Hygiene
For State Registrar	Certificate o	of Death Reg. No. 1) 6
1 Decedent's Nan	na (First Middle Last)	2 Date of Death

1. Decedent's Name (First, Middle, Las			Cer	titicati	e of L	Death		R	eg. No	IJIJ	0	11901	
	st) aldi							2. Date of Dea Month April	th Day	20	9 0 6	3. Time of Death	
4a. Facility Name (If not institution, give		r)				Location of	of Death		4c. County of Death Baltima				
5. Social Security Number 6. S 216-12-5836	birthday)_ Yrs.	If Under Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day June 9,	Year)	24		place (State or Foreigntry) UKAND			
Usual Residence of Decedent  10a. State  10b. County  Maryland  Baltim	ore	10c. City, T										10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
10e. Street and Number  5101 Kenwood Avenue  10f. Zip Code  21206  U.S.,										ntry?			
11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 🌣 Divorced	Armed Forces? If Yes, specify Cuban', Mexican', Puerto Rican, etc.) Black,  1 Never Married 2 Married 1 Yes Sive									ck, White,	American Indian, White, etc. White		
15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	fucation de completed) College (1-4o			rind of wor O NOT us	rk done d se retired)	u <i>ring m</i> os	t of worki	ng			usiness/In		
10th Grade  17. Father's Name (First, Middle, Last)  Samuel D'Agosti			ASS	embly	won	-		(First, Middle,  Jeant	Maiden			) CU.	
19a. Informant's Name/Relationship (						nd Numbe	er or Rura	Bel Air	-			o Code)	
20a. Method of Disposition  1 🔀 Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specification of the content		e cem	e of Dispos etery, crem のれる の	atory or o	ther place	1		- 1			•	own, State Maryland	
21. Signature of Funeral Service Licer		, 0 10 500	22.	Name an	d Addres	s of Facilit	ySch	imunek 7 Baltimor	unc	ral	Home	25	
23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Artenia	line.	notio		1 4					Se		Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of):												
that initiated events resulting in death) Last	Due to (or as a consequence of):  d												
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		e of pregnancy 2 DFetal de at time of death	ath 3 🗆	Ectopic pr Other (sp							te of delive		
												ery Day Year	
Part II. Other significant conditions o	ontributing to death	but not resulting	ng in the un	derlying ca	ause give	n in Part I.		1			tribute to t	Day Year	
Part II. Other significant conditions of	ontributing to death	but not resultin	ng in the und	derlying ca	ause give	n in Part I.		1 Ye	es 21	□ No 24b.	3 Prob	Day Year  the cause of death?  pably 4 XUnknown  posy findings available	
25. Was case referred to medical examiner?						26. Place	of Death	1  Yes a autops perform 1 Yes of (Check only on	n sy ned?	□ No	3 ☐ Prob Were auto prior to co death? 1 ☐ Yes	he cause of death?  pably 4 Vunknow  posy findings available  mpletion of cause of	
25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending	Hospital: 1 ☐ Inpa 28a. Date of In (Month, L	tient 2□ER	Outpatient	3□ DO	Othe	26. Place  T: 4 □ Nu at	of Death	1  Yes	n sy med? 2 No	□ No    24b.	3 Prot Were auto prior to co death? 1 Yes	he cause of death?  pably 4 Unknown  posy findings available  mpletion of cause of	
25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death	Hospital: 1 ☐ Inpa  28a. Date of In (Month, E	tient 2□ER	/Outpatient b. Time of Injury	3□ DO 2	Bc. Injury Work	26. Place  r: 4 □ Nu	of Death irsing Hor '	1 Yes  24a. Was a autops perfort 1 Yes  (Check only on the state of th	n sy ned? 2 No ned? 2 No ned? 2 No ned? 2 No ned? 2 No ned? 2 No ned? 2 No ned ned ned ned ned ned ned ned ned ned	No 24b. 6 Oth y occur	3 ☐ Prot Were auto prior to co death? 1 ☐ Yes  mer (Specif red	he cause of death?  pably 4 Unknown  posy findings available  mpletion of cause of	

0

State Registrar

within 24 hours after death.

To the Funerel Diractor: After this certific completely filled in by the funeral director.

29b. Signature and title of certified

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Philip Militello, MD 6 Trimble Hill

31. Date filed (Month, Day, Year)

APR 1 2 2006

32 Registrar's Signature 6 Trimble H:11 CT. Lutherville, MD 21093
32 Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

D18667

29d. Date signed (Month, Day, Year)

April 10, 2006

#### Please Type or Print in Black Indelible Ink

aphael, Vernon	State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death	
Physician/	Registrar Reg No.	3. Time of Death
ledical Examiner		Year 6:20
	4a Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	: County of Death
	Good Samaritan Hospital Baltimore	
Funeral Director	Months David Have Marin A	/DD/YYYY) 9. Birthplace (State or Foreign Country)
	214-94-9791 1XM 2 F 57 Yrs. World's Days Hours Min. 3-25-4	7 Trinidad
any	10a. State 10b County 10c. City, Town or Location	10d. Inside City Limits
ith the Maryland 23a or 28a-f show notified at once. al Director	5 MD Baltimore	1 Yes 2 No
the Maryland a or 28a-f sh tiffed at one Director	10e. Street and Number 10f. Zip Code 10g. Citi	zen of What Country?
th the 23a or notifie	805 St. Dunstans Road 21212	USA
or death with or items 23. must be no	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	<ol> <li>Race - American Indian, 8lack, White, etc.</li> </ol>
fer de F.or er.m.		Specify: Plack
ours aft atural" xamine	or Dates:	Kind of 8 usiness/industry
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exar Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)	1 .
5-0036 led within 72 tygiene. other than the Medical	17. Father's Name (First, Middle, Last)  HOUSE KEEPING  18. Mother's Name (First, Middle, Maiden	tospitaL
		Surname)
AD 2121 2 should be finand Mental 27 is marked matic event,	19a Informant's NamerRelationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, C	ity or Town, State, Zip Code)
MD d 2 sho lth and n 27 is aumati	Karen C'Kanhaol (W4)3816 (.) Longes Ave. Ra	1to MD 21215
ore, M es l and 2 of Health If item 2 her traun	20a Method of Disposition  20b. Place of Disposition (Name of cemetery)  Date 20c.  1 8urial 2 Cremation 3 Removal from State crematory or other place)	Location - City or Town, State
Baltimore, osemit. Pages I ar Department of Hee Department of Hee Important: If ite njury or other tr		Salto-MD
Baltimo permit. Page Department Important: injury or oth	4 Donation 5 Other Specify:  21 Signature of Funeral Service Licenses  22 Name and Address of Facility  23 Name and Address of Facility  24 Table 1	al Services
Physician	23a. Part I. Elver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory/arrest, sho	LAND AND AND AND AND AND AND AND AND AND
/Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease	8etween Onset and Death
Examiner	or condition resulting in death)  Due to (or as a consequence of):	
<u>.</u>	Sequentially list conditions, b.	
ed nsit Examiner	if any, leading to immediate Due to (or as a consequence of):  cause. Enter Underlying Cause  Chicago or injured that injured Co.	
Exar	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
n and I - transit		
Records, P.O. Box 68760,  The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transicompleted by Physician/Medical E.	F FEMALE: 23c If yes, outcome of pregnancy 23d	Date of delices
587( rrifica ling ph an/N	E IF FEMALE: 23c If yes, outcome of pregnancy 23c 23c If yes, outcome of pregnancy 23c 23c If yes, outcome of pregnancy 23c 23c If yes, outcome of pregnancy 23c 23c If yes, outcome of pregnancy 23c 23c If yes, outcome of pregnancy 23c 23c 23c If yes, outcome of pregnancy 23c 23c 23c 23c 23c 23c 23c 23c 23c 23c	d Date of delivery Month Day Year
Box 687 death certificante attending per deattending per use as the strain of the stra	4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown 9 Unknown	
D. By the de by the iched f	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco	use contribute to the cause of death?
i, P.O. ires that the signed by ville detach	1 Yes 2	No 3 Probably 4 ✔ Unknown
Records,  The law require ficate has been sign, page 2 should be	24a Was an	24b. Were autopsy findings available
e law e has l ge 2 sh	autopsy performed?	prior to completion of cause of death?
		o 1 Yes 2 No
Division of Vital I Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certified in by the funeral director, al Certification: To Be C	examiner?	nce 6 Other:
n of ling Ph After t funeral	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury 28c. Injury at Work?	iry occurred
trendi teath. tor: , the fi	1 V Natural 5 Pending 2 Accident Investigation	
Division of spital or Attending I tours after death. nerral Director: After filled in by the function.	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street a or Town, State)	nd Number or Rural Route Number, City
y fill		
the hin ple	To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and one)  2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place.	d manner as started. ice, and due to the cause(s)
To con Mec	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. I	Date signed (Month, Day, Year)
		18, 2006
h	30. Name and address of person who completed cause of death (Item 23a)	
C	Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State	e 31. Date filed (Month, Day, Year)  32. Registrar's Signature	
Registrar	THE REAL PROPERTY OF THE PARTY	
DHMH 17 Rev 1/2001	ORIĞINAL	

DHMH 17 Rev 1/2001 OCME 10/2003

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10,2006 DOROTHY MARIE REMBSKI April 6:20P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Masonic Home Cockeysville Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) March 15, 1919 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 215-09-2935 87 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23e or 28e-f show traumatic event, the Medical Evantier mast be notified at 10d. Inside City Limits 1 Yes 2XXNo Director Maryland Baltimore Cockeysville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 International Circle 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 7 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 🗆 YesX XX No Specify: White þ XX Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George August Klein Helen Victoria Mann 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norman F Spector Son 605 Hastings Road Towson, Maryland 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State permit. Page Department o important: if any injury or once. injury or □Donation 5 □Other (Specify) Hebrew Friendship 4/12/06 Baltimore, Maryland Signature of Funeral Sprvice Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Erul Stage Con Physician /Medical Due to (or as a consequence of) Examiner our auto Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an page 2 autopsy 25. Was case referred to medical examiner? 1 Yes 2 XNo Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 24 and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) V21464 4-11-06 wells, mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto, Mul 21227 NO 3508 ROBERT LIBERTS. Bank 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State APR 1 2 2006 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year CARL 3:49PN AFRIL 2006 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BON SECOURS HOSPITAL BALTIMONE 5. Social Security Number Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year) 11-24-1935 Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 □ F 241-46-2949 70 Director NC Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other then "nature!", or iteme 23a or 28a-f ehow 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or iteme 23a or 28a-1 ehov traumatic event, the Madical Experiment must be notified at **Funeral Director** MD XXYes 2□No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2100 Boyd St 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes XX No Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Specify: **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Assistant Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic events. Carl Reid SR Mary Lee Reid 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Renee Forney 1448 Washington Lane, Catawba, NC 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 DRemoval from State Smygna Cemetery 4-15-06 4 Donation 5 Other (Specify) Catawba, NC 21. Signar ire brising and storing livers Gregory MO1148 426 Crain Hwy, SW, Glen Burnie, MD 21061 er the disease or the disease or domplice art failure. List only on ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** Olax dial /Medical Due to (or as a consequence of): Examiner YOYSequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of use as the burial-transit erten Division of Vital Records, P.O. Box 68760, ettending physician and Due to (d as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Month 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 1 Yes 2 No 3 Probably 4 € Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 20 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After 1 Naturat 5 Pending investigation 1 Yes 2 No 2 Accident completely filled in by the 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MBENUE FALLS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 = For State Registrar		State o	f Marylai		artment of F ertificate of	Health and M <i>Death</i>	lental Hy	/giene Reg. No.	006	11465
			Decedent's Name	(First, Middle, La	st)					2. Date of D	eath	Maria	3. Time of Death
	Physic		Shirley Ann Rawlings							12011	Day 4	2006	12:05PM
	/Med Exami		4a. Facility Name (If					4b. City, Town, o	or Location of Death		4c. C	ounty of Death	
	LAGIIII	nei	Baltimon	al I la clair	M notion	1.10	andere	Glen Bu	Ni na		D.	nne Ar	Labour
~	Funeral		5. Social Security No		iex Title	7. Age (In yrs	. last birthday	) If Under 1 Year	If Under 24 Hrs.	8. Date of Bi	irth	9. Birth	place (State or Poreign
3	Director		215 36 7		□M 2□F	67	Yrs.	Months Days	Hours Min.	(Month, D		Mary	yland
~			Usual Residence of		$\Lambda\Lambda$	07		1		Aug 1	3, 193	28	,
10	yland Now		10a. State	10b. County		10c. C	ity, Town or L	ocation					10d. Inside City Limits
5	Man	ō	Maryalnd	Howard			Sa	vage					1 ☐ Yes 2 ☐ No
(f)	the 28s	Director	10e, Street and Num	nber				10f. Zip Code	-		10g. Citize	en of What Cou	
1	death with the Maryland ims 23a or 28a-f show irmst be notified at	0		orchwood	Drive A	Apt #1A		20763	3		Unit	ed Stat	-00
VI.	eath	Funeral	11. Marital Status		12. Was Deci	-			Hispanic Origin? (Sp	ecty Yes or N		Race - Ameri	
6	iter d	S		ed 2 Married	Armed Fo	rces?	,,,,	If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)		Black, White,	
7	rs of	by	3\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	_	1 ☐ Yes If Yes, Giv Year or D	/e ates:		1 ☐ Yes XX No	Specify:		S	Specify:	White
Rawli	II A 1A 1D-UUSO filled within 72 hours efter Hygiene. ther then "naturel", or fte out, the Medical Execution		1221	15. Decedent's E	1		16a Dec	edent's Usual Occup	nation		16b Kind	d of Business/Ir	
3	n 72	Completed		ify only highest gra	de completed)		(Giv	e kind of work done DO NOT use retire	during most of work	ting	700. 14.110	3 01 00011100011	idostry
OF S	the state	Ĕ	Elementary/Secon	ndary (0-12)	College (1-4or 5+)			maker		Own Hor			
Ur C	Hygi ct.	Ö	17. Father's Name (	First Middle Last	)				18. Mother's Nam	e (First, Middle			
	ntal l	Be		Earl Hu		1				Elino			
•	y IO	2					10: 11:						- 0-411
	2 st 2 st 2 st 1 and 1 in n	4	19a. Informant's Na			. \				ural Route Number, City or Town, Sta			
	end end eelth m 27		Tracy Ri	<u>_</u>	laugntei				rings Sou				
	of H its		20a. Method of Disp	oosition ⊒Cremation 3 □	Removal from	State 200.	cemetery, cre	on (Name of ematory of other pla	ce) April 1	<b>1</b> , 2006			
	Peg Tient Tient Tient			5 Other (Special			Washin	gton Nati	onal Ceme	tery			laryland
	Baltimore, Maryland Z 1 Z 13-0030 permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Depertment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show princy or other traumatic avent, the Medical Examinar must be notified at any follows.		21. Signature of Fu	neral Service Lice	0660		_   4	22. Name and Addre	ess of Facility Lee	Funera	al Hom	e,Inc 6	633 Old
1	2055		Must	NOF	Jah 1.	10015	-3	Alexandri	a Ferry R	oad, Cl	linton		0735
			23a. Part1. Enter th	ne disease, or com	plications that	aused the dea	ath. Do not er	nter the mode of dyi	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (	Final	One cause on e	m -	-	-	1				Onset and Death
	/Medical		disease or condition resulting in death)	n /	a. Due to	(or as a conse	auence of	quelog	facle	ue			·
	Examiner				20010	3.			/ -		711.		and the same of th
		ē	Sequentially list con	nditions, mediate	b. Due to	(or as a conse	quence of):	me ca	recorra	-, we	any	near	estatie
12	/ per l	Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or	rtying injury							0		
1.	cate be executed physicien and the burial-transit	xa	that initiated events resulting in death) L		c	(or as a conse	quence of):						
	cate be exphysicien the burial											Î	
		dlcal			d								
Ì	Certif	N.	IF FEMALE:		23c. If yes, ou	come of prear	nancv				25	3d. Date of deliv	1081
(	BOX better the control of attending processes as a for use as	la	23b. Was decedent in the past 12	months?	1 ☐ Live t	oirth 2 ☐ Fei nant at time of	tal death 3	☐Ectopic pregnanc ☐ Other (specify) _	:y		23	Month	Day Year
(	Shed the G	ys	1 ☐ Yes 2 € 9 ☐ Unknown		9□ Unkn		Geath 5						
(	UNISION OF VITAL RECORDS, P.O. BOX of or Attanding Physician; The law requires that the death.  Director: After this certificate has been signed by the attending in by the tuneral director, page 2 should be detached for use as	by Physician/Me	Part II. Other signif	icant conditions	contributing to d	eath but not re	sulting in the	underlying cause on	ven in Part I.	23e. Did	I tobacco us	e contribute to	the cause of death?
	sign at be							, <b>,,</b>		1	Y9\$ 2□	-	bably 4 Unknown
	w require	Completed	l										
	4eC elaw hest	후								24a. Wa aut	opsy	prior to co	opsy findings available ompletion of cause of
	The The sets he page	9								1 ☐ Yes	formed? 2 C No	death? 1 ☐ Yes	2 □ No
	VITAL F lician: Th certificete rector. pag	Be	25. Was case refere	red to medical					26. Place of Deal	th (Check only	one)		
	ysic nis ce	2	1 ☐ Yes 2 €	No	Hospital: 1 1	Inpatient 2	□ ER/Outpatio	ent 3□ DOA Ot	her: 4 🗆 Nursing Ho	ome 5 Res	sidence 6	Other (Speci	fy)
	On or VITa ding Physician; h. After this certific tuneral director,		27. Manner of Death	h 5 □ Pending	28a. Date (Mon	of Injury th, Day Year)	28b. Time Injury		ry at	28d. Describe	how injury	occurred	
	VISION Attandir death. ctor; At	atte	2 Accident	investigation					Yes 2 □No				
•	VIS Pr de pr de by ti	l ₩	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not to determined	289. Place	of Injury - At	home, farm, s	treet, factory, office		28f. Location	(Street and own, State)	Number or Rui	ral Route Number,
i	D set in B	Certification:				3, (	,,				,,		
	DIVISION To the Hospital or Attant within 24 hours efter deat To the Funaral Director; completely filled in by the	ca	29a Certifier (Check only	1 Certifying P	hysician: To the	hast of my kr	nowledge des	on a bounded at the ti	ima date and clana opinion, death occur	and due to the	e causa(s) a	and manner as	stated
	n 24 he Fi plete	Med	one)	Z I MOCICAL CX	and man	ner stated.	ation and/or	investigation, in my	opinion, death occur	ned at the time	a, date and p	place, and due	to the cause(s)
_	To t Withi To t	Σ	29b. Signature and	title of certifier		_		29c. Licen	se number		29d. Date	signed (Month	, Day, Year)
			1 0	1/8 mis	Som.	dell	)	Doc	14147		April	1620	06
	3		30. Name and addr	ess of person who	completed cau	se of death (Ite	əm 23a) (Type	e, Print)			-//		10 2106)
			William	Daid	son 3	05 H	spita	1 Dr 50	Ne 3cs	6le	n Bus	rine 1	10 21061
	S	tate	31. Date filed (Mon		32. F	Registrar's Sig	nature						1
	Regis	trar	AP	R1 2 200	6	Registrar's Sign	K A	348					
	100				- 4		-						

Please Type or Print in Black Indelible Ink

smith, Clemus	1- For State Amend Item#20b pe Registrar	and / Department of r FH 6854rical 144	Health and Mental F	Hygiene Reg No. 2	006 1146
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last)		3 Time of Death 22:23		
$\bigcirc$	Clemus L. Smith, II  4a. Facility Name (if not institution, give street and not Bon Secours Hospital		o. City, Town, or Location of Deat Baltimore	April 10, 2006 th 4c. Coun	ty of Death
Funeral Director	5. Social Security Number 6. Sex 214-84-6935 1X M 2 F	7. Age (In yrs. last birthday) 46 Yrs.	If Under 1 Year If Under 24Hr Months Days Hours Mi		YY) 9. Birthplace (State or Forei Country) MD
any	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location	n		10d Inside City Limit
<b>*</b>	MD	Baltimo			1 Y Yes 2 N
Maryland 28a-f show 1 at once. ector	10e. Street and Number	3 41 5 2 11 10	10f. Zip Code	10g. Citizen of	Λ
hours after death with the Maryland natural", or items 23a or 28a-f shov Examiner must be notified at once. ed by Funeral Director	1812 Baker Street  11. Marital Status 1 X Never Married 2 Married Armed F	cedent Ever in U.S. 13. Was	21217 Decedent of Hispanic Origin? ( Ss, specify Cuban, Mexican, Puerte	Specify Yes or No-	ce - American Indian, Black,
er death , or iter r must	1 Yes 3 Widowed 4 Divorced If Yes, Give Yes	2XX No			nite, etc.
5-0036 ed within 72 hours after tygiene other than "natural" he Medical Examine Completed by	or Dates:  15. Decedent's Education (Specify only highest gra		Yes 2 No s <i>pecify:</i> s Usual Occupation (Give kind of	Specify work done 16h Kind of	Black Business/Industry
64 ° -1 TO	Elementary/Secondary (0-12) College (	during	orking life. DO NOT use retired)	TOD. KING OF	business/industry
15-0036 filed within 72 I Hygiene ed other than 't, the Medical e Compler	10	Labo		Cons	truction
15-( filed of Hyging ed oth to the	17. Father's Name (First, Middle, Last)		18 Mother's Name	e (First, Middle, Maiden Surnar	ne)
21215-0036 ould be filed within 7 Mental Hygiene s marked other than it event, the Medical TO Be Comple	Clemus L. Smith, Jr.  19a. Informant's Name/Relationship (Type, Print)	19h Mailing	Bever Address (Street and Number or	ly Carter	Chair The Code
imore, MD 21215 Pages 1 and 2 should be file, nen of Health and Mental Hy ant: If item 27 is marked o or other traumatic event, th	Vicky Hill/Sister		Cedarmere Circl		
Ce, I 1 and 1 healt Fitem r trat	20a. Method of Disposition	20b Place of Disposit			s, MD 21117 n - City or Town, State
altimore, rmit Pages I ar pariment of He portant: If ite lury or other ir	1 X Burial 2 Cremation 3 Removal fr 4 Donation 5 Other Specify:	om State crematory or othe Mt. Zion			MD
alt mrit port ury	21. Signature of Funeral Service Licensee	22. Na	me and Address of Facility Jan	mes A. Morton	imore, MD & Sons F H Ind
	James 9. Mg	$\sim$ 17	01-31 Laurens S	t. Baltimore.	MD 21217
Physician /Medical	23a. Part I. Enter the disease, or complications that c tailure. List only one cause on each line.	aused the death. Do not enter the	mode of dying, such as cardiac of	or respiratory arrest, shock, or h	Approximate Interva Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death)		ing liver cirrhosis		Death
)	b	consequence of):			
ner	if any, leading to immediate Due to (or as a	consequence of):			
red nsit <b>Examiner</b>	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a	consequence of):			
	d.				
760, cate be execu physician and he burial - tra	X UNPENDED AMENDED	item#23a,PII,27, <sub>1</sub>	perMe,g854,4/27/06	TT	
P.O. Box 68760, that the death certificate be death of the attending physicia detached for use as the buriably Physician/Medii	23b. Was decedent pregnant in the past 12 months?	ant at time of death	I death 3 Ectopic pregna	23d. Date ancy Month	of delivery Day Year
Box death he atte d for u	1 Yes 2 No 9 Unknown 9 Unknown	5 U Otne	er (Specify)		
s, P.O. I	Part II. Other significant conditions contributing to	death but not resulting in the un	derlying cause given in Part I.	23e. Did tobacco use con	tribute to the cause of death?
s, P.( bires that signed d be det	complications of procitis			1 Yes 2 No	Probably 4 Vunknown
Records, The law require: ficate has been sig, t page 2 should be				24a. Was an 24b. autopsy	Were autopsy findings available prior to completion of cause of
Recc The lav				performed?	death?
ital Recition: The licion: The licion: The licions sertificate licetor, page	25. Was case referred to medical examiner?		26.Place of Death (Check	only one)	
F Vil Physic er this ral dire	1 ✓ Yes 2 No	npatient 2 ER/Outpatient		ng Home 5 Residence 6	Other:
Division of Vital rat or Attending Physician rs after death at Director. After this certiled in by the funeral director artification: To Be	27. Manner of Death  1 X Natural 5 Pending 2 Accident Investigation	of Injury 28b Time of Inju Day,Year)	ıry 28c. İnjury at Work?  1 Yes 2 No	28d Describe how injury occu	rred
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the edical Certification: To Be Completed by Physician/		e of Injury - At home, farm, street,	factory, office building, etc.	28f. Location (Street and Num or Town, State)	ber or Rural Route Number. City
To the Hos within 24 h To the Fur completely	29a. Certifier 1 Certifying Physician: To the bes one) 2 Medical Examiner: On the basis of and manner st	f examination and/or investigation	d at the time, date and place, and n, in my opinion, death occurred a	d due to the cause(s) and manner at the time, date and place, and	er as started due to the cause(s)
· <b>S</b>	29b. Signature and title of certifier	. 0	29c. License number	29d. Date sig	ned (Month, Day, Year)
3	anesz	. Mo	O.C.M.E.	April 11, 2	1006
oter	<ol> <li>Name and address of person who completed caus Ana Rubio MD. Assistant Medical E</li> </ol>		eet, Baltimore, MD 21201	1	
State Registrar	31. Date filed ( <i>Month</i> , <i>Day</i> , Year) 32. R	strar's Signature	K)		
DHMH 17 Rev 1/2001 OCME 10/2003	1 2 2000	ORIĞINAL			

	1 - State	State of M	/laryland /		rtment of H	lealth and N Death		iene	06	1467
	1. Decedent's Name (First, Middle, Last)							h		3. Time of Death
Physician	Gholam Reza Sad	iadi M.D.					April 6, 2006			7:21 PM M
/Medical Examiner	4a. Facility Name (If not institution, g		r)		4b. City, Town, o	r Location of Death			c. County of Death	
	Gilchrist Center	r for Hosp	ice Car	e		Towson		Bal	timore	)
Funeral Director	5. Social Security Number 6. 219-34-2166	Sex 7. A 1 <b>X</b> M 2□ F	Age (In yrs. last i	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 03/22/	Year) 1917	9. Birth Cou Iran	
7	Usual Residence of Decedent									
death with the Maryland ms 23a or 28a-1 show traust be notified at meral Director	10a. State 10b. County		10c. City, To	wn or Loc	cation					10d. Inside City Limits
a-f-e	MD Baltim	ore	Luth	ervil	lle Timor	nium				1 🗋 Yes 2 🙀 No
or the	10e. Street and Number				10f. Zip Code		10	0g. Citizen	of What Cou	ntry?
C (Samith wi	1810 Dulaney Val	lley Road			21093				d Stat	
	11. Marital Status  1 Never Married 2 Married	12. Was Deceder Armed Forces 1 Yes 2	s?		Vas Decedent of H Yes, specify Cuba ☐ Yes 2 2 No	dispanic Origin? (Span, Mexican, Puerton Specify:	pecify Yes or No- Pican, etc.)	E	Race - Ameri Black, White, I <sup>cify:</sup> <b>Whi</b>	etc.
21215-0036 de within 72 hours at get than "natural", or the Modical Exem	3 N Widowed 4 □ Divorced	Year or Dates								
A-1-1 21215-00 ed within 72 hou yejener ner than "nature nt, the Medical E	15. Decedent's (Specify only highest g		16	Give i	ent's Usual Occup	pation during most of world)	king		f Business/Ir :h Care	•
A (*) 2121(	Elementary/Secondary (0-12)	College (1-4o	r 5+) <b>5+</b> ]		cal Docto			carc	Oar	-
nd 2121 nd 2121 le filed within la Hygiene. John the Ma	17. Father's Name (First, Middle, La		<u> </u>				ne (First, Middle, M	Maiden Sum	ame)	
Viand Syland Syland Syland Syland Syland Hyge Mental Hyge attreed other attree or To Be C	Kazem Sadjadi	,					eh Sadjad		•	
Maryland Maryland A 2 should be file of 2 should be file traumatic avent traumatic avent	19a. Informant's Name/Relationship	(Type Print)	1	9b Mailin	n Address (Street	and Number or Ru	ral Route Number.	City or To	wn. State. Zii	o Code)
Mar Mar d 2 st Tie n n traun		daughter			-					nonium, MD
other tra	20a. Method of Disposition		20b. Place	of Dispos	sition (Name of natory or other place		Date	20c. Locatio	on - City or T	own, State
Baltimore, permit Pages 1 at Department of Hee Important: It lean any Injury or othe page.	1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		Ches	apea	ke Crema	tory	2000			Maryland
Œ	21. Signature of Funeral Service Lig	ensee V	089001			ess of Facility and Funera Pastures				ryland
0	23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caus ly one cause on each	ed the death. D	o not ente	er the mode of dyir	ng, such as cardiac	or respiratory arre	est,		Approximate Interval Between
Physician	Immediate Cause (Final disease or condition	Lev	kema							Onset and Death
/Medical	resulting in death)		as a consequenc							, ( ( ) ( )
Examiner	Supportion but conditions	Myc	elo dusp	with	c Syndr	me			`	years
, B	Sequentially list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	Due to (or a	as a consequenc	ce of):						,
8760, sale be executed bhysicien and the burial-transit dical Examiner	that initiated events									
	resulting in death) Last	Due to (or a	as a consequent	ce of):						
8760 sate be e physicien the burie		d								<del></del>
P.O. Box 68761 hat the deeth certificate be d by the attending physicic letached for use as the bu	IF FEMALE:								1	
, P.O. Box 6: that the deeth certific ed by the attending p detached for use as	23b. Was decedent pregnant in the past 12 months?		2 Fetal dea	ath 3	Ectopic pregnancy	y		23d.	Date of deliv Month	гөгу Day Year
o de de hed fr	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant 9□Unknown	at time of death	5 ∟	Other (specify)			1		,
P.O. that the debt by the detached detached	Part II. Other significant conditions	t contributing to death	hut not resultin	a in the ur	ndarhina causa an	ven in Part I	23e Did tob	acco use o	contribute to	the cause of death?
Cords, P w requires that s been signed to should be det	Fatth, Other significant conditions	commonly to deat	TOUCHOL TOUGH	g in the or	idenying cause gre	rent in a divi.	1 □ Ye	.1		bably 4 Unknown
Division of Vital Records, or Attending Physicien: The law requires that derice and the Director and the tuneral director, page 2 should be certification; To Be Completed by								- 1		
Rec elaw has b							24a. Was a autops	n 24 y	tb. Were auto prior to condeath?	opsy findings available empletion of cause of
Cor Cor							perform 1 Yes 2	No _	1 ☐ Yes	2□ No
Vital	25. Was case referred to medical examiner?	Hogottal:			0#		th Check only on	1		
of V	1 Yes 2 No	Hospital: 1 ☐ Inpa		Outpatien	3 DOA		ome 5 Reside			mylaspie
Division of Vital Release and a standing Physicien: The related death.  I blinector: After this certificate he din by the tuneral director, page Certification; To Be Com	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Ir (Month, I	Day Year)	b. Time of Injury	Wor		28d. Describe ho	w injury oc	currea	
isio ktendi death. ctor: A y the fu	2 Accident investigat 3 Suicide 6 Could not	h-		,		]Yes 2□No	284 1		- h O	al Route Number,
or At their of Direction by in by	4 Homicide determine	289. Place of	etc. (Specify)	, tarm, str	et, factory, office		City or Town		im <i>ber</i> or Aur	al Adule Number,
oitel ours a rail of lead of l	1000									
Division of Vital Records, P.O. Box 68  To the Hospitel or Attending Physicien: The law requires that the deeth certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the tuneral director, page 2 should be detached for use as a Medical Certification; To Be Completed by Physician/Mec		Physician: To the be aminer: On the basis and manner	of examination							
thin 2 thin 2 the imple	29b. Signature and title of certifier	andmailiei	Stateu.		29c. Licens	se number	2	9d. Date sid	gned (Month	Day, Year)
\$ 1 × 1 × 1	250. 350.120.00	2 100				58303		FRAIL		006
	, your					2010		.1		
15	30. Name and address of person wh	and wall	VI CL	olas (	Ch RMI	mue us	21204			
	31. Date filed (Month, Day, Year)	32 Pagi	strar's Signature	~~>			•			
State Registrar	APR 1	2 2005	7 Olymanure	H	hack .					
DHMH 17 Rev 1/2001	MIL	2 2006	ALLEN S	-						

Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day 2006 **Physician** 1:15 pm April 8, Michael Stershic, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) **Examiner** Harford Bel Air Lorien - Bel Air 8. Date of Birth (Month, Day, Year) NOV. 19, 1924 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1Q,M 2□ F Yrs. 219-18-5953 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Marylend 10d. Inside City Limits 10c. City, Town or Location 10b. County Departmant of Health end Mantal Hygiene. Important: If Item 27 is marked other than \*naturel; or Items 23s or 28s-f show eny Injury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 ☐ No **Funeral Director** Md. Baltimore Perry Hall 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21128 U.S.A. 4501 Dunton Terrace, Apt. J Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐¥Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by white 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) stee1 supervisor 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Yurick Michael Stershic 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 56 Huxley Circle, Abingdon, Md. 21009 Stephen Stershic/son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition t Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith Cem. 4/11/06 Baltimore, Md. 21. Signatur J. Funeral Servica Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air, Inc. 21014 610 W. MacPhail Road, Bel Air, Md. 23a. Paul. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwee Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical METASTATIC LIVER Examiner Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 1 ☐ Yes 2 No 3 ☐ Probabiy 4 ☐ Unknown PROSTATE CANCER DLON CANCER, þ 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has been significate has been significated function, page 2 should? 24a. Was an autopsy performed? Be Completed DIABETES MELLITUS 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 - Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No 28e. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Deeth 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No investigation within 24 hours after death.

To the Funeral Director: All completaly filled in by the fu 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D45344 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 16 Rev 6/95

State

SURESH DHAN. 31. Date filed (Month, Day, Year)

APR 1

DHANJANI

**ORIGINAL** 

MI

32 Registrar's Signature

622 S. UNION AVE, HAVRE DE GRACE, MD 21078

Rudney Smith 06-02337 UNK, UNK Physiciá Medical Examir Funeral Director permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, MD 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink

	State 1. For State	of Maryland / Depa			ygiene	2006	111.6
_	Registrar		rtificate of Dea	tn	Reg. N 2. Date of Death		Time of Death
n™ ier	1. Decedent's Name (First, Middle, Las	Smith			Month Day April 4, 2006		22:38
	4a. Facility Name (if not institution, given John Hopkins Hospital	ve street and number)		Town, or Location of Death more		4c. County of Death	
	20 10 0100	7. Age (In yrs. I	• * *	der 1 Year   If Under 24Hrs. hs Days Hours Min.		IM/DD/YYYY) 9 Birthpl County	ace (State or Foreig y)
	Usual Residence of Decedent  10a. State 10b. County	10c City	Town or Location			10	d. Inside City Limits
ctor	10e. Street and Number	13	atm c	p Code	10g. (	' Citizen of What Country	
J Dire	1601 Stone	WOOD KO	ad	21239		USA	Indian Block
Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorce	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No ad If Yes, Give Year	If Yes, spec	lent of Hispanic Origin? (Spiff Cuban, Mexican, Puerto  No specify:		14. Race - Americar White, etc Specify	2CK
ed by	15. Decedent's Education (Specify of	only highest grade completed)	16a. Decedent's Usua during	Occupation (Give kind of v	work done 168	b. Kind of Business/Indo	ustry
Completed by	Elementary/Secondary (0-12)	College (1-4 or 5+)	1	ife. DO NOT use retired) Finishe			ction
Be	17, Father's Name (First, Middle, Las	ith	1 0 17 0	Kath	e (First, Middle, Maid	Allen	~~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~
υ	Darnel V. A	Men Brother	- 8353	SS (Street and Number or I Arbor Sta	tion Wa	y to Kuil	eMD
•	20a. Method of Disposition  1 Burial 2 Cremation 3		Place of Disposition (Na crematory or other place		Date 20	Rolling City or To	wn/ State
	4 Donation 5 Other Specification of Funeral Service Lice	ensee	Car Hill 22. Hame an	diAddress of Facility	e True	ral Serv	ices
	23a Part I. Enter the disease, or com	mol3 63 explications that caused the death	n. Do not enter the mode	5 dyling such as cardiac	claspiratory arrest,	6. AID 2	Approximate Interval Between Onset and
	landro. Electorny one sauce on t	-	cotic intoxic	ation complicate	ed by acute	asthma	Death
ner	if any, leading to immediate	b.  Due to (or as a consequence	of):				
Examine	events resulting in death) Last	c. Due to (or as a consequence	of):				
ledical	X UNPENDED	d. AMENDED <b>item#23</b> 8	a,27,28a-f,per	ME,g855,5/24/06	TT		
Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred  Live birth  Pregnant at time of d	2 Fetal dear		ancy	23d. Date of delivery Month Da	y Year
Phys	1 Yes 2 No 9 Unknow  Part II. Other significant conditions	9 UNKNOWN	resulting in the underlyi	ng cause given in Part I.	23e. Did tobac	cco use contribute to the	e cause of death?
d by							oly 4 V Unknown
omplete					24a. Was an autopsy performe	prior to cor	psy findings available in pletion of cause of 2 No
Be	25. Was case referred to medical			26.Place of Death (Check	only one)		
To B	examiner? 1 ✓ Yes 2 No		P ER/Outpatient 3			sidence 6 Other:	
Ju: 1	27. Manner of Death  1 Natural 5 Panding	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work?  1 Yes 2 X No	28d. Describe how	v injury occurred	
catic	Natural 5 Pending 2 Accident Investig	pation 17 47 2000	10:00 PM		unk	eet and Number or Rura	Route Number Cit
Sertific	3 Suicide 6 X Could n 4 Homicide		none, ram, street, facto	лу, онice building, etc.	or Town, State		TROUGH HAIRDER, OIL
dical Certification:	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my knowle ner:On the basis of examination and manner stated					

State Registrar

29b Signature and title of certifier

Assistant Medical Examiner Theodore King MD. 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

April 5, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** MONZ; 3 20% /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hodry Attack 5. Social Security Number Hosp 9. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 6 56 7. Age (In yrs. last birthday) If Under 1 **Funeral** Months Days Hours Min. 1**X**M 2□ F 83 Yrs. NC 215.16.2688 Director 0.14. Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits · how Baltimore NA 1 Noves 2 No MD Funeral Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 2310 Allendale Road 21216 death or iteme Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after anent of Health and Mental Hygiene. antit I feen 27 ie marked other than "natural; or fite ury or other traumatic event, the Madical Examina ury or other traumatic event, the Madical Examina 1 Never Married 2 Married ☐Yes 2 NO Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates: Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Self-Employed Welder 8th grade 17. Father's Name (First, Middle, Last) UNL 18. Mother's Name (First, Middle, Maiden Surname) Strickland ္ Elizabeth Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Buckingham Batto. MD 21207 Road 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages I Depertment of H Important: If ite eny injury or of once. 04/08/06 1 ⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Address of Facility
C. Greeke Funeral Services
York Road Baltimore MD 21212 leur 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** myocardist Enfarction disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Quality (or as a nonsequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed ng physicien and as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. by Physician/Medical ettending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) signed by the e 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes Division of Vital 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Tes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 31. Date filed (Month, Day, Year) da Ulton brer land

DHMH 17 Rev 1/2001

State

Registrar

**ORIGINAL** 

32. Registrar's Signature

APR 1 2 2006

			For	State of Ma		d / Depa	artme	ent of H			ital Hy	gien		<b>e.</b>	
			Registrar  1. Decedent's Name (First, Middle, Last)				unca	ile UI I	Jeani	2.	Date of Dea				3. Time of Death
	Physicia /Medic	_	Robert Edwin Seign	nan							Month (	L(		ear NG	12:30 AM
	Examine		4a. Facility Name (If not institution, give	street and number)			4b. Cit	y, Town, o	Location of Dea		1	40	. County of I	Death	
			5. Social Security Number 6. Sep	of Ball	7		bc	Uti/ ler 1 Year	nove (L	y			N/		
	Funeral Director		246 <b>-</b> 70-4505	M 2□F 7. Ag	60	ast birthday) Yrs.	Month		Hours Mir	1.0	Date of Birt Month, Da 11y 29	v. Year.	945	Country	ce (State or Foreign 1) land
	and	+	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							100	I. Inside City Limits
35	Mary	ģ	Maryland N/A		В	altimo	ore								1XYes 2 □No
E G	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if Item 27 is marked other than "natural", or Itema 23a or 28a-f show any Injury or other traumatic avent, Ite Mcdical Examinar rulat te notified at ADGE.	Funeral Director	10e. Street and Number 3101 Keswick Rd.				4	Zip Code 21211					tizen of Wha		
	deat ma	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13.	Was Dec	edent of H	ispanic Origin? ( n, Mexican, Pue	Specify	Yes or No		14. Race -	American White, etc	
21215-0036	ours after	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 XXDivorced	Armed Forces?  1 Yes 2 1 1 Yes, Give Year or Dates:	No			2 X No	Specity:		,		Caralle.	whit	
200	72 hc	eted	15. Decedent's Edu (Specify only highest grade	cation e completed)		16a. Deced	dent's Us kind of v	ual Occup	ation during most of wo	orking		16b. F	(ind of Busin	iess/Indu	stry
7 5	within ane. than	Completed by	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. i		use retired cher	0				educat	-ion	
OSS nd 2	filed Hygid other	ပိ	17. Father's Name (First, Middle, Last)	<del></del>		-	tea	ciler	18. Mother's Na	me (Fi	rst, Middle,			.1011	
lan	Aental Aental rked tlc av	To Be	Edwin Lincoln Seig	gman					Ruth (	Corr	e11				
Baltimore, Maryland	2 short		19a. Informant's Name/Relationship (Ty			1	-		and Number or F						ode)
€, <b>≥</b>	1 end 1ealth em 27 ther tr	-	Melissa Seigman Ra	abush/dau				swick		3alt Date	imore				Chair
nor	ages of of the		1 ☐ Burial 2 【X Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		ace of Dispo emetery, crer					0006		ocation - Cit		
3 =	artine partine corten Injuri	}	21. Signature of Funeral Service License	90 1177	Gre	enmour 22	nt C	remat and Addres	ory Apr.	. TT	,2006	Ba	iltimo	re, I	Maryland
E E	Per Per Per Per Per Per Per Per Per Per		Dobu O. Mitch	ella				Mitch 6500	ss of Facility 11-Wied York Rd	lefe	ld Fu Balti	ner	al Hom e, MD	ne 212	pc.
Ratim Baltim			23a. Por 1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused ne cause on each lin	the death. ne.	. Do not ent	er the m	ode of dyin	g, such as cardia	ac or re	spiratory ar	rest,		A	pproximate iterval Between
	Physician /Medical	W	Immediate Cause (Final disease or condition resulting in death)	Acute		enal	Fai	lure	-						Surces.
	Examiner			Due to (or as	a consequ	ience of):								,	sdays
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Du to (or as	a consequ	ence of):									75
	e be executed rsicien end e burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	)											
760,	B icie B	<u>8</u>		Due to (or as	a consequ	ience or):									
	ificate g phys as the			J											
XO	th cert tendin r use	an/M	230. Was decedent pregnant	3c. If yes, outcome 1 □ Live birth	of pregnan	ncy death 3	Tectopic	pregnancy					23d. Date of		
Division of Vital Records, P.O. Box 68	To the Hospitel or Attending Physicien: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physcompletely filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Medic	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□Unknown			Other (						Month	Da	ay Year
٥.	that the hed by detact	y Ph	Part II. Other significant conditions cor	ntributing to death b	ut not resu	Iting in the u	nderlying	cause give	en in Part I.		23e. Did to	obacco	use contribu	ite to the	cause of death?
rds	w requires been sign should be	o o o	Small bowel	obstruc	hon						1 🗆 Y	es 2	□No 3[	] Probab	y 4 Unknown
ဓင္ဝ	law requas been 2 shouk	plet									24a. Was		24b. Wer	e autops	y findings available eletion of cause of
<u>~</u>	ilcian: The lav certificete has rector, page 2	S									perfo	rmed?	deat	th?	≥No .
Vita	certifi	Be	25. Was case referred to medical examiner?	lospital:				Oth	26. Place of De						
of	Phys ar this arat di	5 To	27. Manner of Death	28a. Date of Inju	rv	PVOutpatien 28b. Time of	_	28c. Injun Work	4 🗆 Nursing				6 □Other ( ry occurred		
io	ath. rr: Afte	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Da)	y Year)	Injury	М		k? Yes 2 □ No						
<u>Š</u>	or Atte	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc	ury - At hor c. (Specify)	me, farm, str	eet, facto	ory, office		28f.	Location (S City or Tow	Street al	nd Number o	or Rural R	Route Number,
	pitel ours al leral D		29a. Certifier 1 Certifying Phys	sician: To the best	of my knou	uladna daatt	2 000011556	ed at the time	o data and also	o and	dua ta tha	201120/2	) and mana		
	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medicai	(Check only 2 Medical Examile one)	ner: On the basis of and manner sta	examinati	on and/or in	vestigatio	on, in my o	pinion, death occ	urred a	t the time,	date an	d place, and	due to th	e cause(s)
	To the To the comp	¥	29b. Signature and title of certifier	1		···	2	9c. License	number			29d. Da	ite signed (A	Aonth, Da	y, Year)
		34	Dewind M.	D.,				KES	-000			ADO	ie 1	10,5	700%
/	0	50	30. Name and address of person who co	mpleted cause of d	eath (Item	23а) (Туре,	Print)	10	Baltim	NP		V			
	Stat	e	31. Date filed (Month Day Year)	32. Registra	ar's Signati	ure 110	DITTE	7	W-1111	11 -					
	Registra	r	HLK I % 7	UUO K	see s	M. M.	Dates . Alle								

DHMH 17 Rev 1/2001

			For State Registrer	State of Mary		artmen rtificat			and M	•	giene Reg. No.	06	11472
	Physici	an	1. Decedent's Name (First, Middle, Last)					_		2. Date of De Month	Day	Year	3. Time of Death
( m	/Medic	al .	Christine			45 0%		adma:		04	08	2006 ounty of Deat	2:40p M
	Examin	er	4a. Facility Name (If not institution, give: Joseph Richey H					more			40.0	ounty of Deat	
	Funeral Director		5. Social Security Number 6. Security Number 1 219-16-7788	7. Age (In	yrs. last birthday)	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Bir (Month, Da 10 0	7 <sup>Year)</sup> 2	9. Birti Co	hplace (State or Foreign unity) MD
-	and w		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation							10d. Inside City Limits
	Manyli f sho	ō	MD NA	В	altimor	e							1∭Yes 2☐No
	7 28a	Director	10e. Street and Number			10f. Zip	Code				10g. Citize	n of What Co	untry?
	th with	ai D	2327 Windsor Av	e			2	1216				U.S.A	•
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tial Hygiene. Indoorher then "natural", or fleme 23s or 28s-1 show event, the Modical Examiner mail be mailfied at	Completed by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		Was Decedif Yes, spe-		ispanic Ori in, Mexican Specify:		cify Yes or No Rican, etc.)		. Race - Ame Black, White pecify:	
2-0	72 ho	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Dece	dent's Usu	al Occup	ation du <i>ring m</i> os	t of worki	na	16b. Kind	of Business/	Industry
21	within sene.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)				during mos		.3	TT d	1	Don't Ctox
2	e filed within il Hygiene. other then vent, the Me		11th grade  17. Father's Name (First, Middle, Last)	na	Cafe	eteri	La C		or's Name	(First, Middle			Dept. Stor
anc	ntal Hed of	Be								a Will		,	
Ž	2 should by and Menta Is marked sumatic e	ို	McNeil Johnson  19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Maili	ng Address	(Street			J Route Numb			Zip Code)
	and 2 s ealth ar n 27 ls		Charlotte Stead	lman-Daugh									21216
Baltimore,	- I a =		20a. Method of Disposition	2	20b. Place of Dispo					ate		ation - City or	Town, State
E C	Pages nent of ant; If Its ary or o	li	1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Ponation 5 ☐ Other (Specify)		Arbutus				13/0	06	Arbu	tus,	Md
alti	permit. Page Depertment of Important: If any injury of		21. Signature of Funeral Service Licens	99				ss of Facilit					
<u> </u>	20 E # 9		Phymia 1.	5.7	4.	$I$ _00 $E$	Naba	Wes	ve.	Balti	more	. Md	21215
	Priysician		23a. Part I. Enter the disease, or compl shock, or hear failure. List only o Immediate Cause (Final disease or condition		ocreation				cardiac c	r respiratory a	rrest,		Approximate Interval Batween Onset and Death
	Medical Examiner sicien and purial-transit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	Due to (orlas a co	onsequence of):								
68760,	5 × 6	icai		d								1.	
.O. Box	The law requires that the death certificat the has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	⊒Ectopic p ⊒ Other (s <sub>j</sub>		, 			23	d. Date of del Month	ivery Day Year
rds, P	w requires that been signed b should be deta	ρ	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	Inderlying (	cause giv	en in Part I			tobacco use Yes 2 🗆		o the cause of death?
Vital Records,		Completed								24a. Was auto perfo 1 \( \text{Yes}		24b. Were as prior to death?	utopsy findings available completion of cause of
Vita	siclan: T certificat rector, pa	Be	25. Was case referred to medical examiner?	Hospital:			Oth	00		(Check only			Manas
ō	ding Phys J. After this funeral di	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient  28a. Date of Injury (Month, Day Ye	2 ☐ ER/Outpatie 28b. Time o lnjury		28c. Injur Wor	4 [] 140		me 5 Res 28d. Describe			city) HOSPICE
Division	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	- At home, farm, st Specify)	reet, factor	y, office				Street and wn, State)	Number or R	ural Route Number,
	ne Hospit 17 24 hours 18 Funara Jetely fille	edicai C	29a. Certifier (Check only one) 2 Medical Exami	ner: On the basis of example and manner stated	amination and/or in	In decumed executed	at the tr	ne, date an pinion, dea	nd place, ath occurr	and due to the ed at the time	date and p	nd Tan of at place, and due	e to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier					e number				signed (Mont	
	1		> 2=180 M	>			D	2417	0		April	8,20	06
	h		30. Name and address of person who c	ompleted cause of death	h (Item 23a) (Type	Print)	- 1		5	Utimo	1	10 -	
			31. Date filed (Month, Day, Year)	chey Hospic	e 538	N.E	utai	NST	13,	Utimo	LE L	11/2	1201
¥.,	Sta Regist		APR 1 9. 20		M. A.	order.							

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🕦 🕦 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9:00 AM 10, 2006 Virginia M. Smith Apri1 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner St. Elizabeth Nursing Center Baltimore City If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2€F Months Days Yrs. Director 188-12-3835 03/23/1922 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Directo MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8430 Smallwood 21122 Court U.S.A. within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Catholic Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12 Secretary Charities 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fil ment of Health and Mental H tent: If item 27 is marked oth Edwin M. Smith Not Available 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8430 Smallwood Court, Pasadena, MD 21122 Donna Cleckner / Niece Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 □ Burial 2 X Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 04/11/06 Baltimore, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, PA Depent Import any in 21. Signature of Funeral Service Licenses 169 Riviera Drive, Pasadena, MD 21122 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failufe. List only one cause on each line. tmmediate Cause (Final disease or condition resulting in death) **Physician** Dementia Years /Medical Due to (or as a consequence of) Examiner Seizure Disorder Year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine ysicien and e burial-transit The law requires that the death certificate be executed Hypertension Years resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 2 Fetal death 3 Ectopic pregnancy Month Day signed by the a 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown م Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bage 2 s autopsy performed' 1 ☐ Yes 2 ☐ No 2 X No of Vital Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4M Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₺ No this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending death. investigation 1 Yes 2 No nerel Director: A filled in by the fi 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funerel Direct completely filled in by 4 ☐ Homicide o the Hospitel 29a. Certifier 1🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dav. Year) 29c. License number 29b. Signature and titte of certifier MO D55391 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ming Yi, 3320 Benson Avenue, Baltimore, Maryland 21227

DHMH 17 Rev 1/200

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 2 2006

32. Registrar's Signature

Selection of the second

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#18, perFit 0854, 9854, 4/12/06 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Stevensor **Physician** 42 P M HILYander 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Maryland Balt MOVE
If Under 1 Year If Under 24 Hrs Medical Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours 216-92-7465 Usual Residence of Decedent 1 M 2 F Director with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show other traumatic event, the Medical Exeminer must be notified at 1 Yes 2 □ No Director MARYLAND 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 14. Race - American Indian, or items 23a 50 AVE. death v by Funeral . Was Decedem Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or item any injury or other traumatic svent, the Mudical Exercit Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 00 K 11 THGRADE 18. Mother's Name (First, Middle, Maiden Sumame)
Abraham 17. Father's Name (First, Middle, Last) Be STEVENSON WILLIAM THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 410 PARK AVE DLA STEVENSON WIFE BALTO, HD. 21205 ATTERSON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Lecation - City or Town, State 20a. Method of Disposition 1⊠Burial 2 ☐ Cremation 3 ☐ Removal from State YCEMETERY 4-13 4 ☐ Donation 5 ☐ Other (Specify) lams 2145 N. FULTON AVE 21. Signature of Funeral Service Licenses JR. FUNERAL HOME 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HUPOVERTI /Medical Due to (or as/a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Was an Morbid Obesita 2 No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Director: After this certification by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2√ No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident 5 Pending 1 ∏Yes 2 ∏No death. investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number. City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide within 24 hours a

To the Funeral 6

completely filled the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) outh 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2006

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma	aryland / I		rtment of H		_	giene Reg. No.	106	11475
	Physicia	an	1. Decedent's Name (First, Middle, Las	,	mallu	200	- 0		2. Date of De Month	Day	Year	3. Time of Death
	/Medic Examin	ai	4a. Facility Name (If not institution, give		marra	700	4b. City, Town, or	Location of Death	APTIL	10 4c. 0	2000 County of Death	, 5:50 AM
		•	Burton Care		llion		Ва	ltimo				
	Funeral Director		5. Social Security Number 6. Sec 219-12-9440	x	e (In yrs. last bi 96	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da 3 – 19 –	th ly, Year) 09	9. Birth Cou MD	place (State or Foreign ntry)
			Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	m or l o	antion					10d. Inside City Limits
	Maryla f shov	ior	MD 100. County		Bal							1√2 Yes 2 □ No
	th the	Director	10e. Street and Number				10f. Zip Code			10g. Citize	en of What Cou	ntry?
	s 23e		5505 Hopkins Ba	.yview C:		12 1	21224	enanio Origin? /S	nacify Vac or No	USA	4. Race - Ameri	can Indian
980	within 72 hours efter death with the Maryland ene. then "naturei", or items 23e or 28e-f show he Madical Ezethirar musiter colified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	Armed Forces?  1 Yes 271  If Yes, Give Year or Dates:		i	Was Decedent of Hi f Yes, specify Cubar I□Yes 凇\\\	Specify:	o Rican, etc.)		Black, White,	, etc.
21215-0036	72 hor	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a	(Give	lent's Usual Occupa	furing most of wor	king	16b. Kin	d of Business/Ir	ndustry
121		ompi	Elementary/Secondary (0-12) 7th	College (1-4or	5+)		oo not use retired, omemaker			На	ome	
nd 2	e file Il Hyg othe	Be C	17. Father's Name (First, Middle, Last)				Juemaker	18. Mother's Nan		, Maiden S		
Maryland		2	Issac Jackson  19a. Informant's Name/Relationship (7)	ima Brintl	10	h Mailir	ng Address (Street a	Susan			Tour State 7	n Code)
	and 2 s		Adrianne Hill	ура, глиц								
Baltimore,	ges 1 and 2 of Heelth if item 27 or other tre		20a. Method of Disposition  1√3Burial 2 □ Cremation 3 □	Removal from State	Cernete	BIV. CIBI	Pacebro sition (Name of natory or other place	9)				
tim	Pa in the land		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service #cen		Mount		armel. Name and Addres	1	4-06		dalk,M	
Ba	permit. Departrimporte any inju		Miller of Pulled Service Scene	Marin	k		007 East		_		•	
			23a. Part1. Enter the disease or companions shock, or heart failure. List only of	lications that caused one cause of each li	the death. Do	not ent	er the mode of dying	g, such as cardiad	or respiratory a	rrest,		Approximate Interval Between Onset and Death
	Fny <del>sicia</del> n /Medical		Immediate Cause (Final disease or condition resulting in death)	a. En	d-St	ag	e Der	nentic	٧			Mouths
	Examiner			bue to (or as	a consequence	1/25	cular	Dise	ease			Vears
-	sit s	iner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	ā Surisequatica	uty.			31-33			1
<u>,</u>	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as	a consequence	of):						
8760,	cate be executed physicien and the burial-transit	dicai		d								
Box 6		an .	23b. was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Petal deat	h 3[	Ectopic pregnancy			23	3d. Date of deliv	
P.O. B	t the d by the	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ Ho 9 ☐ Unknown	4□Pregnant a 9□Unknown			Other (specify)				Month	Day Year
	res tha signed I be det	by	Part II. Other significant conditions of				wound			tobacco us Yes 2 □		the cause of death?
Records,	w require been si should I	Completed	Chronic anen	$\alpha$	Chron	10	Wound	,3	24a. Was		24b. Were aut	opsy findings available
Re	The law cate has page 2 s	omo							auto		prior to co death?	ompletion of cause of 2 ☐ No
Vital	Phyeicien: Th this certificate al director, pag	BeC	25. Was case referred to medical examiner?	Hospitali			Othe		ath (Check only	one)		
of	Phys rthis ral di	. To	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpati	ırv 28b.	Time o		4 Nursing F	lome 5 ☐ Resi 28d. Describe			ify)
ion	불극호호	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		y Year)	Injury		Yes 2 □ No				
Division	i Site	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of in	jury - At home, f c. (Specify)	arm, str	eet, factory, office		28f. Location ( City or To		Number or Rui	ral Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical C		ysician: To the best niner: On the basis of and manner st	f examination a							
	To th withir To th comp	Me	29b. Signature and title of certifier	L U.	<b>D</b> .		29c. License	0568	06	AD	e signed (Month	D, 2006
	i		30. Name indaddress of person who			(Type,	Print) 505 Ho	nalina	Barrie	2,) (	icolo	RoH:ma
	Sta	ate	31. Date filed (Month, Day, Year)	Euban 32. pegisti	rar's Signature	. ر	OUS MC	DOKINS	my VIC	w	11.010	, 10111110
	Regist		APR 1 2 2	006 Ace	in 18	A	and I					

			1 - For State Registrer	State of	Maryland		artment <i>rtificate</i>			and M		giene Reg. No.	.UUb	Proposition and Proposition an	476
543	Physic		1. Decedent's Name (First, Middle, Buelah Small)	,							2. Date of De. Month	ath Day	200	r	of Death
Same S	/Medi Examir		4a. Facility Name (If not institution, 9						Location o			4c.	County of De		
	Funeral Director		UNK	. Sex 7.	Age (In yrs. las 90		If Under 1 Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 6-3-	h y, <i>Year)</i> 15	9. B	irthplace (Stat Country)	e or Foreign
	within 72 hours after death with the Maryland ene. than "natural", or iteme 23s or 28e-1 show the Maryland Exp. intert is well be notified at	Funeral Director	Usual Residence of Decedent  10a. State 10b. County  MD  10e. Street and Number			Town or Lo		Codo				10- 04		XX	City Limits es 2 □ No
	ath with	rai Dir	6119 McBeth D	r.				1239	)			USA	zen of What (	country?	
9036	ours after des ral', or iteme Exeminer tu	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☆ Widowed 4 □ Divorced	12. Was Deceded Armed Force 1 Divers 2 If Yes, Give Year or Date	os? ☐ No		Was Decede f Yes, speci 1  Yes 2		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	1	14. Race - An Black, Wh Specify: B		,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23s or 28e-f show any injury or other traumatic event, Ite Medical Exportment must be notified at ance.	Completed	15. Decedent's (Specify only highest (Elementary/Secondary (0-12) 12th	Education grade completed) College (1-4		(Give life. L	dent's Usual kind of work DO NOT use	k done d e retired)	ition during most	of worki	ng		nd of Busines	s/industry	
Maryland (	uld be filed Mental Hyg irked otheric event,	To Be C	17. Father's Name (First, Middle, La James Edwards								(First, Middle, Wallac	Maiden			
more, Mar	and 2 sho ealth and N m 27 is ma		19a. Informant's Name/Relationship	(Type, Print)							l Route Numbe				
Baltimore,	. Pages 1 tment of H tant: If Itel		20a. Method of Disposition  1♥ Surial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe	city)	te Tri	nty	natory or ou	iei piace	4	-13·	-06	Dun	dalk,	MD	
Ba	Depar Depar Impor any in		21. Signature of Fundal Service Lie	chas	1/2	20	007 E	Cast	ern	Ave	sley C .Balto	. M			
	Physician /Medical Examiner		23a. Part1. Enter the disease of conshock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. SEF Due to (or	TIC as a conseque	S IP	OCK				r respiratory ar	rest,		Approxim Interval B Onset an	Between
		Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	· LORDI	CAL as a consequer VARY as a consequer	nce of):  ART	UBITU								
38760,	icate be executed physicien and s the burial-transit	dicai			CIAL A		ATIO	V							
Division of Vital Records, P.O. Box (	or Attending Physician: The law requires that the death certifulate death. Differd eath. Differd this certificate has been signed by the attending in by the funeral difector, page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 1 No 9 □ Unknown		2 Fetal de at time of deat	eath 3	Ectopic pred Other (spec					2	3d. Date of de Month	elivery Day	Year
rds, P	w requires that been signed b should be det		Part II. Other significant conditions THROM BUEME	contributing to death	but not resulting	ng in the ur	iderlying cau	use givei	n in Part I.			bacco us		to the cause o	f death?
al Reco	ysician: The law re is certificate has be director, page 2 sh	Completed										sy med? 2)U No	24b. Were a prior to death?	utopsy finding completion of s 2 2 No	s available cause of
$\equiv$	ysicia is certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	itient 2 ER	VOutpatient	1 3□ DOA	Other	-	-1-1-0	Check only on		Other (So	acifu)	
sion o	or Attending Phys after death. Director: After this in by the funeral di	Certification;	27. Manner of D ath 1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could not	28a. Date of le (Month, i		Bb. Time of Injury		c. Injury Work		2	8d. Describe h			SCHY)	
Š			4 Homicide determine	building,	njury - At home etc. <i>(Specify)</i>		_				8f. Location (S City or Tow	n, State)			ımber,
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	one)	Physicien: To the be eminer: On the basis and manner	oi examination	edge, death n and/or inv	estigation, ii	n my opi	nion, deatr	place, a occurre	d at the time, c	ate and	place, and du	e to the cause	
}	\$ 1 8 1 E	_	29b. Signature and title of certifier	MD			R	ES-	- 00C		2		4/07/	2006	
00	3		30. Name and address of person who NIHARIKA DIXIT, 31. Date filed (Month, Day, Year)	5601, LO	LU RAN	IAN B	VULEN	ARD	. BAL	TIM	CRE, MO	. 2	120301		
	Sta Registr	-	man and	Sz. riagi	atrar's Signatur	l v	NO D	-							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			101	partment of Health and	Mental Hygie	ne 2006   11.77
2			Registrar  1. Decedent's Name (First, Middle, Last)	ertificate of Death	Rag.	No. U U 3. Time of Death
2	Physici /Media		ROBERT HOOPER SMITH		Month	Day Yeer 9:15p M
70	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat	h	4c. County of Death
0	Funeral		GILCHRIST  5. Social Security Number	TOWSON  ay) If Under 1 Year   If Under 24 Hrs	8. Date of Birth	BALTIMORE  9. Birthplace (State or Foreign
0	Funeral Director		212-34-8069 XPM 2DF 78 Yrs.	Months Days Hours Min	JULY 12,	1927 MARYLAND
00	and w		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or	Location		10d. Inside City Limits
1	Marylan I-f show	ţō	MD BALTI	MORE		1 XYes 2 No
)	ith the M or 28a-f	Olrec	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?
7	within 72 hours after deeth with the Maryland ene. than "natural", or itama 23a or 28a-f show the Medical Examinar musi be notified at	Completed by Funeral Director	1111 BRYNMAWR	21210	Sanata Van an Na	USA  14. Race - American Indian,
, (0	after de or itam minar	Fun	Armed Forces?  1 Never Married 2 Married 1 M Yes 2 No	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	to Rican, etc.)	Black, White, etc.
77- -0036	rai', o	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 <b>]</b> [] No Specify:		Specify: WHITE
3 1	in 72 h	lete	(Specify only highest grade completed) (Gi	cedent's Usual Occupation ive kind of work done during most of wo b. DO NOT use retired)	rking 16b	. Kind of Business/Industry
0 212	filed with Hygiene. ther ther	mo		NANCIAL ANALYS	r F	INANCIAL
SY E	\$ \frac{1}{2} \frac{1}{2} \frac{1}{2}	Be	17. Father's Name (First, Middle, Last)  ROBERT HOOPER SMITH		me (First, Middle, Maid 7 DDTCE D	den Surname) CICHARDSON
_ <u>~ 5</u>	d 2 should the and Men 7 is marke traumatic	٩		ailing Address (Street and Number or Ri		
4 ₹	Tan T			1 BRYNMAWR RD.		
ore.	T T T T			sposition (Name of rematory or other place) RIDGE APRIL	Date 2006	Location - City or Town, State
altim	Pa nen ury		4 Donation 5 Other (Specify)  21. Signature of Fune (Alexender Unersee	22. Name and Address of Facility	98	
	permit. Depertr Importa		MONAGO	16924 YORK RD		
			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardia	c or respiratory arrest,	Approximate Interval Between Onset and Death
-0	Physician /Medical		tmmediate Cause (Final disease or condition resulting in death)	lic prostate	CANCEL	1 year
	Examiner		Due to (or as a consequence of):	V		0
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	cate be executed physicien and ithe burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last			
68760,		dicai	d			
89			IF FEMALE:			valle va
Вох	Jeath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery  Month Day Year
P.O.	t the de by the ached	hysic	1 Yes 2 No 4 Pregnant at time of death 9 Unknown 9 Unknown	Oli Other (specify)		
	res that the dea igned by the a be detached for	þ	Part II. Other significant conditions continuing to death but not resulting in the		- 1	co use contribute to the cause of death?
ord	w require been sign	eted	abstructive lung disens	<u> </u>	1 Tes	
Division of Vital Records,	he law e has l	Completed			24a. Was an autopsy performed	
ital	ysician: The lis certificete ha director, page	BeC	25. Was case referred to medical examiner?	26. Place of De	1 ☐ Yes 2 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	No 1 Yes 2 No
of V	Physic this ce al dire	ဥ	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat			6 DOther (Specify) +OSPICE
on (	ding Phy h. After thi funeral o	tlon	27. Manner of Death   Value   Society   Pending   28a. Date of Injury   28b. Time   Injury		28d. Describe how in	njury occurred
visi	Attan er deat ector: by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Street City or Town, St	t and Number or Rural Route Number,
Ö	ital or urs afte ral Dir lled in					
P	To the Hospital or Attanding Physician: The law requires that the death certify within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edical	29a. Certifier (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)	eath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the cause urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
_	To the To the compl	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)
-	15		If thothers they, und	025205	Afr	pril 11,2006
6	The state of the s		30, Name and address of person who completed cause th (Item 23a) (Typ	De Print) Charles St.	bolto.	Md 2120x
	Sta		31. Date filed (Month, Day, Year) APR 1 2 2006	ule		
	Registi	ar	HILL TO COOL THE SEA OF SOME			

DHMH 17 Rev 1/2001

			1 - For Stata Registrar	State of I				nt of H	ealth a		ental Hy		e) ] [	T. Company	1478
8	Physic	ian	Decedent's Name (First, Mid	ddle, Last)							<ol><li>Date of De Month</li></ol>	ath Da	ay Yea	ar	3. Time of Death
ei.	/Medi	çal	John Walke								pril 8	7	006		6:30 A M
	Exami	ner	4a. Facility Name (If not institut		9r)				Location of	f Death		40	County of D		
	Funeral	ξų .	3044 Soundii 5. Social Security Number		Age (In vrs.	last birthday)		Jewoc 1 Year	DCL If Under 2	24 Hrs.	8. Date of Bir	th	Harfo		ce /State or Foreign
	Funeral Director		306-42-2584	1⊠M 2□F	61	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year	1944 II	Country ndia	ce (State or Foreign
	P .		Usual Residence of Decedent								Apr. 2	.0,	1944 1	ICILC	uia
	ehow	-	10a. State 10b. Coun	•	10c. Cit	ty, Town or Lo	ocation							100	I. Inside City Limits
	he M	ecto	Maryland Harfo	ord	Edo	rewood	11-								1 ☐ Yes 2 XNo
	with	Funeral Directo		Drive			10f. Zip	1040				10g. C	tizen of What	Country	y?
	feath me 23	era	3044 Soundin	12. Was Decede	nt Ever in U	.S. 13.			spanic Orig	in? (Spec	ify Yes or No	-	USA 14. Race - A	merican	Indian
9	after o	규	1 Never Married 2 M	Armed Force	s?					Puerto R	ify Yes or No ican, etc.)		Black, W		
03	72 hours after death with the Maryland natural', or Iteme 23a or 28a-f show disal Examiner must be codified at	1 by	3 ☑ Widowed 4 □ Divorce	ed If Yes, Give Year or Date:	s:		1 🗌 Yes	2 <b>X</b> No	Specify:				Specify:	Wh	ite
21215-0036	72 h natu	Completed	15. Decede (Specify only high	ent's Education hest grade completed)		16a. Dece (Give	kind of wo	rk done di	urina most	of working	g	16b. h	(ind of Busine	ss/Indu	stry
121	within lene.	m	Elementary/Secondary (0-12	) College (1-4c)	or 5+)		DO NOT u	se retired)							
	Hygie Hygie other		17. Father's Name (First, Middle			MTTT7	Ltary		18. Mother	's Name /	(First, Middle,		Sumame)	ernm	ent
lan	Mental Mental arked o	To Be	Lloyd (unk)	Walker							n) Enq				
Maryland	E E E	-	19a. Informant's Name/Relation			19b. Mailii	ng Address		Emma nd Number				or Town, State	a, Zip C	ode)
	1 and 2 Health a iem 27 Is		Kathy Lynn Sa	ms / Wife		3044	Sound	ding	Drive	, Ed	gewood	, MI	21040	)	
ore	of Hea of Hea fitem		20a. Method of Disposition 1 □@urial 2 □ Cremation	2 Demoval from Sto	20b. P	Place of Dispo emetery, crei				Da			ocation - City		n, State
Ē	Pages ment of ant: If It ury or o		4 Donation 5 Other		Da	ırlingt	on Ce	emete	ry   4	-12-	06	Dar.	Lington	1, M	aryland
Baltimore,	permit. Pages 1 Department of H Important: If Ite eny injury or ot once.		21. Signature of Funeral Service	e Licensee		22 N	Name an	d Address	s of Facility	Home	e, P.A				_
A.A.S	# D = • 0		(ussell)	ly		1	.317 (	lokes	burv	Road	. Abin	ador	ı, Mary		d 21009
			23a. Part1. Enter the disease, shock, or heart failure. Li Immediate Cause (Final	st only one cause on each	line.	n. Do not ent	er the mod	e ot dying	, such as c	ardiac or	respiratory ai	rest,		Ir	pproximate Iterval Between Inset and Death
199	Physician /Medical		disease or condition resulting in death)			CELL	LU	NG	CANC	CR			·	4	month
*	Examiner			Due to (or a	as a consequ	uence of):								'	
- C		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (o. a	as a consequ	uence of):									
pl	ocuted nd transi	Examiner	that initiated events	c											
90,	be executed sician and burial-transit	EX	resulting in death) Last	Due to (or a	as a consequ	uence of):									
8760,	physic physic the b	Physiclan/Medical		d										-	
9 X	eath certific attending p	/Me	IF FEMALE:	23c. If yes, outcom	ne of pregna	incv									
Вох	atter 1 for u	clan	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 4☐Pregnant	2 🗌 Fetal	death 3	Ectopic pr						23d. Date of o Month	delivery Da	ay Year
P.O.	at the de by the a	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown											
ω̈́.	The law requires that the death certificate to has been signed by the attending physicage 2 should be detached for use as the	by P	Part II. Other significant condi	tions contributing to death	but not resu	ulting in the u	nderlying ca	ause givei	n in Part I.		23e. Did to	bacco	use contribute	to the	cause of death?
Records,	w require been sig should b	ed					_				×	es 2	□No 3□	Probab	ly 4 ∐Unknown
ဝင္ပ	law ras be	pie									24a. Was		24b. Were	autopsy	findings available
	The cate has page	Completed									perfor	med? 2 X No	death		
Vital	nding Physicien: 1 th. : After this certifical funeral director, p	Be	25. Was case referred to medic examiner?							of Death	Check only o	ne)			
ţ	Phys this al dir	은	1 Yes 2 No	Hospital: 1 Inpa		ER/Outpatien			4 🗀 INUIS				6 □Other (Sp	oecify)	
o	ding h. After fune	ţ	1 Natural 5 ☐ Pend		Day Year)	28b. Time of Injury	M	8c. Injury Work?	at ? es 2∐No		d. Describe h	iow inju	ry occurred		
Division	Attending r death.	fica	3 ☐ Suicide 6 ☐ Could	d not be 28e. Place of I	njury - At ho	me, farm, str					f. Location (S	Street ar	nd Number or	Rural R	oute Number.
ă	in Jire	Certification:	4  Homicide detei	building,	etc. ( <i>Specif</i> y	()	,	,			City or Tow	m, State	9)		
	To the Hospitel or Attenct within 24 hours after death To the Funerel Director: completely filled in by the total completely filled in by the total completely filled in the total completely filled in the total completely filled in the total completely filled in the total completely filled in the	edical (	29a. Certifier (Check only one)  Certify  Certify  Certify	ing Physician: To the best al Examiner: On the basis and manner:	or examinat	wledge, death tion and/or inv	occurred a	at the time in my opi	e, date and nion, death	piace, an	d due to the o	ause(s date and	and manner d place, and d	as state	ed. e cause(s)
	To the within To the compl	Me	29b. Signature and title of certification			-/oncord	290	License	number			29d. Da	te signed (Mo	nth, Da	y, Year)
			Sein of	T		/51442	D ""	-515	555			04	- 11 -	200	6
	16-11		30. Name and address of person	n who completed cause of	death (Item	23a) (Type,	Print)	_	_						
	י ענין		SEIN AUNG 31. Date filed (Month, Day, Yea		tenela Cianat	h		D,	SUITE	212	- 1 BE	L All	e MD	210	15
	Sta Registr		APR 1 2. 7	#W	trar's Signat	lure Since	E .								

				1 - For State of Maryla		artment of tificate of			iene 0	6	-	9			
	3			Decedent's Name (First, Middle, Last)				2. Date of Death	1		3. Time of Dea	ath			
		Physic /Medi		Kerry Alexis Smith				Apr.	8 20	Year 006	14:16	М			
	7	Exami		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location of Death	11-	4c. County						
	1 10	\$4.		Upper Chesapeake Medical Cen		Bel A			Har	ford					
	-8	Funeral	П	1□M 2XTF	rs. last birthday) Yrs.	Months Days		8. Date of Birth (Month, Day,		9. Birthp	lace (State or Fo	reign			
		Director		215-48-9778 52 Usual Residence of Decedent	113.			Apr. 21,	1953	Mar	yland				
		yland		10a. State 10b. County 10c.	City, Town or Lo	cation				1	0d. Inside City Li	mits			
		e e	ctor	Maryland Harford	Bel Air	2					1 ☐ Yes 2 <b>X</b>	] No			
		ith the Marylar or 28e-f show	Director	10e. Street and Number		10f. Zip Code		10	g. Citizen of V	Vhat Coun	try?				
		ath w		1348 Gates Head Drive		2101	.4		USA						
		er de	Funeral	11. Marital Status  12. Was Decedent Ever in Armed Forces?	U.S. 13. V	Vas Decedent of Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ k, White,					
	36	Ir, or	by F	1 ☐ Never Married 2 【 Married 1 ☐ Yes 2 【 No If Yes, Give 9 Year or Dates:	1	☐ Yes 25 No	Specify:		Specify.	Wh	ite				
11.76	21215-0036	be filed within 72 hours after death with the Maryland hat Hygiene. Id other than "natural", or iteme 23a or 28e-f show event, the Medical Examinat must be notified at	ted	15. Decedent's Education		ent's Usual Occu			6b. Kind of Bu	ısıness/Inc	lustry				
3	215	thin 7	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give )	kind of work done OO NOT use retire	e during most of work red)	ing			,				
~		ed wi ygien ner th	Con	4	Regi	stered	Nurse		Hosp	ital					
	and and	d a b	Be	17. Father's Name (First, Middle, Last)											
	Maryland	d 2 should be th and Mental th smarked ? Is marked treumstic ev	2	Albert Alexander Gibson			Ruth		Lussen	- do					
90/8/4	S	d 2 h a 7 ls	Į.	19a. Informant's Name/Relationship (Type, Print) Robert Smith/Husband			et and Number or Run ead Drive,								
2	စ်	the first		1484-2	. Place of Dispos	sition (Name of			Oc. Location -						
-	9	9 0 = 5		1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	•	natory or other pla		67			aryland				
7	altimore,	- E		21. Sign turn of Funeral Acensee	illtop S	Name and Addr	ress of Facility	11-00			-	_			
	ä	Depa Depa Impo any is		Helle III ana to main	Mc	COmas F	uneral Horesbury Road	pe, P.A.	ion Ma	razlar	nd 2100	a			
				23a. Part 1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.	eath. Do not ente	or the mode of dy	ring, such as cardiac	or respiratory arres	st,	T A T CO	Approximate Interval Between				
4		Physician		Immediate Cause (Final disease or condition METAS	TATIO		LIGNA			and .	onset and Death				
	1	/Medical Examiner		resulting in death)  Due to (or as a conse	equence of):	176	70				12111				
	16	Lxammer		Sequentially list conditions b.											
	1	led Isit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	equence of):										
8	bx	al-trar	хап	that initiated events c. resulting in death) Last Due to (or as a conse	equence of);					-					
5	8760	cate be executed physicien and the burial-transit	dical	4	· ,										
2	9	g phy as the	edic	U.											
7	Вох	death certifi e attending I id for use as	M/U	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fe		F			23d. Date	e of delive	ry				
3	. B	the atte	sicia	1 Yes 2 10 No 4 Pregnant at time of		Ectopic pregnand Other (specify) _			Mor	nth	Day Year				
5	P.O.	that the ded by the detached	Physician/Me	9 - Oliknown											
102U	ŝ	nes ign be	by	Part II. Other significant conditions contributing to death but not re	esulting in the un	derlying cause gr	iven in Part I.		./		e cause of death				
_	0	w requi	eted	Julie Bonze	10/110	UC 110	)/V	1 Tes	2 <b>1</b> No	3 Proba	ibly 4 🗍 Unkno	)WN			
	Records	e law has b	Completed by					24a. Was an autopsy	24b. V	Vere autop	sy findings availa pletion of cause	of			
		LO CT						performe 1 ☐ Yes 2 €	<b>D</b> No 1	eath?	2□ No				
2	Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 Innatient 2 ☐			26. Place of Death								
2	ō	문문	. To	27. Manner of Death 28a. Date of Injury	☐ ER/Outpatient 28b. Time of	3LI DON	4   Nursing Ho	ne 5 Residen 28d. Describe how			)				
2	ion	Attending r death. ector: After y the fune	atlor	1 DNatural 5 Pending (Month, Day Year) 2 Accident investigation	Injury	28c, Inju Wo M 1	ork? ]Yes 2□No		mijary occurr						
5	Division of	ar deg	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spec	home, farm, stre	et, factory, office		28f. Location (Stre	et and Numbe	er or Rural	Route Number,	-			
F		rs afte el Dir	Cer	building, etc. (Spec	y)			City or Town,	State)						
Smith, 1		To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kr  2 Medical Examiner: On the basis of examination of the page	nowledge, death	occurred at the ti	ime, date and place, a	and due to the cau	ise(s) and mai	ner as sta	ited.				
(1)		thin 2 the I mplet	Medical	and marmer stated.								_			
		5 × × 0		29b Signature and title of certified	- hr	29c. Licens	3/17	A.	d. Date signed	(Month, E	2 (T)/-				
				30. Naryleyand address of persop who completed cause of death (lite	om 22c) /T 0	(int) 2 10	2 1113	1-0	1910	0 0	,				
		12		TOTAL PROPERTY AND AND MANAGEMENT OF THE PROPERTY OF THE PROPE	oni coa) (Type, P	LA11	CTANGELY	MA SO	100	Ó	21047				
	-	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Sign	nature	11100	2/01/	Will Rig	L/T/V		-				
		Registra	ar	ADD 1 9 2006	K Aca	well									

**ORIGINAL** 

ROSEMARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** 683/AM hyden Ve 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 1 Year If Under 24 Hrs 5. Social Security Number 21 Timo 8. Date of Birth (Month, Day, Year) 02/01/1912 . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Hours Days Min. 1 □ M Yrs 94 MD Director 213-10-9301 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ed other then "natural", or iteme 23a or 28e-f ahow event, the Medical Exempler must be positived at BALTIMORE 1 ☐ Yes 2 No BALTIMORE Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 4 HARNESS COURT T-4 21208 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No WHITE Specify: If Yes. Give 3 Widowed 4 Divorced ear or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) Coltege (1-4or 5+) SHOE 12 STENOGRAPHER permit. Peges 1 and 2 should be file Depertment of Health and Mental Hy importent: if Item 27 is marked othe eny lightly or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be SALTZMAN SNYDER ROSE SAMUEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9006 PITTSFIELD ROAD - BALTIMORE, MD 21208 JEAN SOLOMON / SISTER 20b. Place of Disposition (Name of cematery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONG. 04/11/2006 WOODLAWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Set 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Party. Enter the disease, for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reservations. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. 

The first formula form Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to (or as a consequence of) Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-translt P.O. Box 68760. Due to (or as a consequence of) Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery jo 3 Fctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) deteched 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ , page 2 should be 2 No 3 Probably 4 Unknown 1 Yes Be Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only onle Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2₺ No Medical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending within 24 hours after death.

To the Funerel Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day

oital Rentallitum mary sand

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LOWTHE

32 Registrar's Signature

		1 - For State Registrar		Marylan		artme	nt of H		d Mental H	lygier Reg. 1	ne ,	6 6	11482
Physici	ian	Decedent's Name (First, Middle, L.	•						2. Date of Month		)ay	Year	3. Time of Death
/Medi			Topper						April		2000	5	6:27 A
Examir	ner	4a. Facility Name (If not institution, g		ir)				Location of E	eath	4	lc. County		
- 10 Bills	. Aller	37 Brookshire						rstown	11		Bal		
Funeral Director		5. Social Security Number 6. 220-68-1251  Usual Residence of Decedent	Sex 7. / 1 □ M 2√ F	51	/ast birthday) Yrs.	Months	Days	If Under 24 Hours		Dav. Yea	954	9. Birth Cou Mari	place (State or Fore into) Land
land •••		10a. State 10b. County		10c. City	y, Town or Lo	cation							10d. Inside City Lim
d 21215-0036 Ifled within 72 hours after death with the Maryland Hygiene. Hygiene. Inthe maches I want the netities at the mode of the mod	ector	Maryland Baltin	ore					tersto	wn				1 □ Yes 2 🔀 I
th with t	Funeral Director	10e. Street and Number 37 Brookshire I	rive			10f. Z	ip Code	21136		10g. (	Citizen of W		ntry?
r dea	Tuel	11. Marital Status	12. Was Deceder Armed Force:	nt Ever in U. s?	S. 13.	Was Dece	edent of Hi	spanic Origin	? (Specify Yes or uerto Rican, etc.)	No-		- Ameri	can Indian,
S afte	Y.F.	1 Never Married 2 Married	1 ☐ Yes 2 2 If Yes, Give				2 X No		30,10 1 110a.1, 010.7				White
urat'.	d by	3 XWidowed 4 ☐ Divorced	Year or Dates	:				ороспу.			Specify:		where
215-0036 thin 72 hours aft e. an "natural", or Modical Exert	Completed	15. Decedent's I (Specify only highest g	Education rade completed)		16a. Dece (Give	dent's Usi kind of w	ual Occupa ork done d	ation furing most of )	working	16b.	Kind of Bus	siness/Ir	ndustry
Mithir ne.	E E	Elementary/Secondary (0-12)	College (1-4o	r 5+)			use retired. Aide	)			les me di		5.44.0
id 212 filed withi Hygiene. other than		12th Grade 17. Father's Name (First, Middle, Las	t) Unk		NWU	se s	ALUE	19 Mathada	Nome /Circl Mid		Jursi		
Vian	To Be		· Offic					18. Mother's	Name (First, Mide	die, Maide	an Sumame	" Un	k
Aar 2 sho and is m	W 3	19a. Informant's Name/Relationship	•						r Rural Route Nui				
ten IV		George Fleckens	tein in-l						ace, Per	ry Ho	ill, 1	1D 2	1128
OTG Of H of H or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	Bemoval from Stat	20b. P	lace of Dispo emetery, crer	sition (Na natory or	me of other place	e) !	Date		Location - (	-	
Pag ment ant: ury c		4 Donation 5 Other (Spec		° Bay	jview (		_		8/2006				Maryland
Daltimofe, permit. Pages 1 a Department of Her Important: If Item any injury or othe		21. Signature of Funeral Service Lice	onsee -						chimunek Baltimo				5
Physician /Medical Examiner with private per private p	icai Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	s a consequ		\ <u>`</u> (	5 4 4						
the death certific	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 Fetal	death 3	Ectopic p Other (s	regnancy pecify)				23d. Date Mont		ery Day Year
uires that	ρχ	Part II. Other significant conditions  DIA Sete	contributing to death	but not resu	Iting in the ur	nderlying	cause give	n in Part I.	11				he cause of death? pably 4 []Unknov
w requir s been s	leted	•							24a. W	ne on	24b W	ara auto	and findings availab
	Сотр								– au	topsy rformed?	pr de	ior to co eath?	psy findings availab mpletion of cause o 2 No
Physician: this certific	Be	25. Was case referred to medical examiner?	Mognitul:				1 = :		Death (Check onl				
	ဥ	1 2 Yes 2 □ No			ER/Outpatien		OA Othe	r: 4 🗆 Nursin	g Home →S□Re	sidence	6 Other	(Specif	y)
- b j j j	on:	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury ay Year)	28b. Time of Injury		28c. Injury Work	at	28d. Describ	e how inj	ury occurre	d	
Attending r death.	cati	2 Accident investigation 3 Suicide 6 Could not to	1			М	1 🗆 Y	es 2 No					
o et in	Certification:	4 Homicide determined	280. Place of It	njury - At hor etc. <i>(Specify</i> )	me, farm, stre )	eet, factor	y, office		28f. Location City or 7	(Street a	and Number te)	or Rura	il Route Number,
To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical (	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the bes miner: On the basis and manners	ot examinati	vledge, death ion and/or inv	occurred	at the time	e, date and pl inion, death o	ace, and due to the	ne cause( e, date ar	s) and man nd place, ar	ner as s	tated. the cause(s)
To the vithin To the comple	¥e	29b. Signature and title of certifier	1			29	c. License	number		29d. D	ate signed	(Month,	Day, Year)
->-0		b hulo	hah.				02	7123		L	1-1		
10	-	30. Name and address of person who	completed cause of	death (Item	23a) (Tune 1			11 57			17/01		
\		Judah Minka	· 120	MA.	- 51	£	کورن ح	7 en 1	·~~	~ D	211	isc	
Sta Registra		31. Date filed (Month, Day, Year)  APR 1 9 20	All .	rar's Signati	Acade .	Me J							

			1- For Amend Item #29d Registrar	State Pily Cast	and/P27 Ce	ortificate of L	lealth and l		giene	6 11483
	Dhysis		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month		3. Time of Death
	Physici /Medi		BRYANT		AYCO,			MARCH	31 200	ear 6 16:38 P M
	Examir	er	4a. Facility Name (If not institution, give s			4b. City, Town, or			4c. County of	
			NORTH WEST HOS  5. Social Security Number 6. Sex		rs. last birthday		LLS TOWA			IMORE
	Funeral Director			M 2□F /. Age (///)	41 Yrs.	Months Days	Hours Min.	(Month, Day	, Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent		11	1		APRIL 2	2 1964	MARYLAND
nylan	how		10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
e Ma		cto	MARYLAND N/A		BAL	TIMORE				1 X Yes 2 No
vith th	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	Director	10e. Street and Number			10f. Zip Code		1	l0g. Citizen of Wh	at Country?
aath v	s 23s	ra	3032 CHELSEA TERF			212			U.S.A	
Ind 21215-0036  be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene.  Department of Health are marked other than "natural", or items 23a or 28a-f ehow eny injury or other traumatic event, the Macical Exeminat must be notified at ODCs.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ②No lf Yes, Give Year or Dates:	n U.S. 13.	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	n, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	Black,	American Indian, White, etc. BLACK
-0C	a a a	ed	15. Decedent's Educ	ation	16a. Dece	dent's Usual Occupa	ation		16b. Kind of Busin	ness/industry
<b>215</b>	Med n	plet	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done a DO NOT use retired,	furing most of wor	rking	rab. Kind of basii	1033/11dd3try
2	general distriction	Completed	12yrs	2yrs	DI	SABLED			N/A	
<b>D</b> #	d oth	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle, i	Maiden Sumame)	
ya ould	Men	မှ	MELVIN RANDOLPH T				LOIS	JANE GRA	VES	
Mar 12 sh	reum reum		19a. Informant's Name/Relationship (Typ	•		ng Address (Street a				
Baltimore, Maryland 21215-0036 semil. Pages 1 and 2 should be filed within 72 hours at	mealther 1		Natasha Taylor/Nie 20a. Method of Disposition		- Contract of the Contract of	Dolphin (  Sition (Name of	St., Apt	the state of the s		
JOE see	: # !!		1   Burial 2 □ Cremation 3 □ Re	1	cemetery, cre	matory or other place	9)	Date	20c. Location - Cit	ry or Town, State
	ntant njury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature Funda Service License	M		CEMETERY  2. Name and Addres		08-06	LANSDOWN	E, MARYLAND
B a	o de la composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della composición della comp		21. Signature 1 that is a vice Electrise		M	ILLIAM C I	BROWN CO		FUNERAL I	HOME P.A.
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on	ations that caused the d		206 W NOR!			est.	Approximate
/N	Medical amd the prival-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, 1 a.y. leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	sequence of):	ONIA				
I Records, P.O. Box 68 The law requires that the death certifica	signed by the attending ph be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	f delivery Day Year
ords, F	been signed should be de	ed by P	Part II. Other significant conditions cont	ributing to death but not	resulting in the u	nderlying cause give	n in Part I.			ite to the cause of death?  Probably 4 Punknown
	s certificate hes be lirector, page 2 sho	Completed by						24a. Was a autops perform	y prio dea:	re autopsy findings available r to completion of cause of th? Yes 2 □ No
VISION Of Vita Attending Physician:	ertific actor,	Be (	25. Was case referred to medical examiner?					th Check only one		
ot of		은	1 165 Z 10		☐ ER/Outpatier		4 L Huising A	ome 5 Reside		Specify)
on in	After thi	5	27. Manner of Death  1 ☐ Matural 5 ☐ Pending	28a. Date of Injury (Month, Day Year,	28b. Time of Injury	Work'		28d. Describe ho	w injury occurred	
ISIO Ittendi	the	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	thoma form et		es 2 No	20f Location (Ct	root and Northern	or Rural Route Number,
	20	ert	4  Homicide determined	building, etc. (Spe	ecify)	eet, ractory, office		City or Town	, State)	or Hurai Houte Number,
Dy To the Hospital or within 24 hours afte	To the Funeral D	edical C	29a. Certifier (Check only one) 1 Certifying Physical Examination	cian: To the best of my left: On the basis of exam and manner stated.	knowledge, death ination and/or in	n occurred at the time vestigation, in my opi	e, date and place inion, death occur	, and due to the ca rred at the time, da	use(s) and manne ate and place, and	er as stated. due to the cause(s)
To th	To th		29b. Signature and title of certifier			29c. License	number	29	od. Date signed (A	
			1/0/		M.	P. DST	722	A	03/31/	2 2006
	1/		30. Name and address of person who con			Print)		1/	111-24	
	1		LEONARD RICHARDS			2T ROAD	RANDA	CLSTOWN	MD 211	33
÷.	Sta Registra		31. Date filed (Month, Day, Year)  APR 1 2 2006	32 Registrar's Sig	nature	alles				

Baltimore, Maryland 21215-0036

Lee, Gertrude

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

		1 - For State Registrar	State of Maryland		rtment of I tificate of		ental Hygie Reg.	211116	11484
Dhamist		1. Decedent's Name (First, Middle, Last)		1			2. Date of Death Month	Day Year	3. Time of Death
Physici: /Medic		GERTRUDE	Lee SA	Kow	rich		April 9		7:28 <sub>0</sub> M
Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	or Location of Death		4c. County of Dea	ath
		Greater Balti			iter	Towson		Baltim	ore
uneral		5. Social Security Number 6. Sex	7. Age (In yrs. la	1.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye		rthplace (State or Foreign ountry)
irector		103 76-2001	18	Yrs.		\$	RPT 23, 1	927	
*		Usual Residence of Decedent  10a, State 10b, County	10c. City	, Town or Loc	ation				10d, Inside City Limits
a ho	ō	MD BALTO			PARK	110			1 ☐ Yes 2 No
288-	Director	10e. Street and Number	11070		10f. Zip Code	riic	100	Citizen of What C	
19 or			DOD RO.		)	1234	109.	U.5.F	
ns 23	Funerai		12. Was Decedent Ever in U.S	S. 13. W	/as Decedent of H	Hispanic Origin? (Spean, Mexican, Puerto F	cify Yes or No-	14. Race - Am	
F F	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No			,	lican, etc.)	Black, Wh	ite, etc.
el', o	by	3 ₩idowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2☐ No	Specity:		Specify: L	shite
natur fical	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decede	ent's Usual Occup	pation during most of working	g 16t	. Kind of Business	s/Industry
Pan .	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retire	d)	9	BALTO :	501 15
ygier it, the	Cor	12+1	NIA		1-each	T			3 Chool 2
d oti	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name			
narke	2	William Luce				GERTRU			
7 Is n traun		19a. Informant's Name/Relationship (Type)	the second secon	19b. Mailing		and Number or Rural		-	
em 2 ther		20a. Method of Disposition	(20b. Pfi	ace of Dispos	ition (Name of	Hill Ave		Location - City o	
Department of read and weather rigident.  Department of read and weather rigident in atural, or thems 23a or 28a-f show any injury or other traumatic event, the Medical Evantmen must be notified at once.		1 Burial 2 □ Cremation 3 □ R	ce	metery, crem	atory or other pla	em. 4/17			
ortan njury		' 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License		-A124	Name and Addre	em , 'III	106	MONIUM	,110,
any and		A Vaul M.	Stopp	P	PUL STE	ess of Facility ILA FUNE CESTE RD.	Rall-ma	21234	,
		23a. Part . Enter the disease, or compli	cations that caused the death						Approximate
/sician		shook, or heart failure. List only on Immediate Cause (Final		0					Interval Between Onset and Death
ledical		disease or condition resulting in death)	Due to (or as a consequ	ence of).	2				
aminer			0	ZUMO					
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequ	ence of):				<del></del>	
nd ransi	Examiner	Cause (Disease or injury that initiated events	ROSI	PIRAT	ORY	FALLURE	OF TA	ACHEOS	Jow 7
ian a urial-l	Ä	resulting in death) Last	Due to (or as a consequent	ence of):		FAILURE 4 LORAT			,,
physician and s the burial-transit	edicai	d	HNOXI	c ca	1CEPITI	4 LOPAT	1 7		
ling p	Me	IF FEMALE:	0 - 1/						
for us	ician/M	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnan 1☐Live birth 2☐Fetal	death 3 ☐	Ectopic pregnanc	y		23d. Date of de Month	Day Year
the shed	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at time of de 9 ☐ Unknown	ath 5	Other (specify) _				
ed by detac	Physi	Part II. Other significant conditions con	tributing to death but not resul	Iting in the und	derlying cause giv	ven in Part I.	23e. Did tobac	co use contribute t	to the cause of death?
sign d be	d by		RENAL 1				1 ☐ Yes	2 □No 3 □ P	robably 4 dunknown
peer	iete				77 (-		24a. Was an	24h Wara a	utopsy findings available
ge 2	Completed						autopsy	prior to death?	completion of cause of
ficate or, pa	e Co	25. Was case referred to medical				00 Pl(P+	1  Yes 2	1√o 1 □ Ye	s 2 No
Scert	o Be	examiner?	ospital: 1 Inpatient 2 E	=B/Outnationt	3□ DOA Oth	26. Place of Death	e 5 ☐ Residence	a 6 DOthar (Sa	noifu)
ar this	<b>—</b>	27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Inju	ry at 2	Bd. Describe how i		SCHY
: Afte	atio	1 Natural 5 Pending 2 Accident investigation	(Мопth, Day Year)	Injury	M 1	rk? Yes 2 ☐ No			
ector by th	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At hor	me, farm, stre	et, factory, office	2	Bf. Location (Stree City or Town, S		iural Route Number,
ad in	Certification:	4 Tiomede	building, etc. (Specily)	/		110	City of Town, 3	tat <del>o</del> )	
when it is now are found in the attentions certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	edicai (	29a. Certifier 1 Certifying Phys (Check only one)	ician: To the best of my knowner: On the basis of examination and manner stated.	vledge, death ion and/or inve	occurred at the tile estigation, in my o	me, date and place, a opinion, death occurre	nd due to the caus d at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
o the	and the same of				29c. Licens	se number	29d.	Date signed (Mon	th, Day, Year)
-0			ATTOMO NG D	HYCLER	N DOC	62739	AD	ral 10	2006
		30. Name and address of person who con	mpleted cause of death (Item	23a) (Type. P	rint) 'Na A	1AU WAIN	36 00	MD	-
		30. Name and address of person who con SGO   Loc ii RAU  31. Date filed (Month, Day, Year)  APR 1 2 200	EN BLUD,	POB-	# 303	, BALTI	MORE.	MDal	239
Sta	te	31. Date filed (Month, Day, Year)	32. egistrar's Signati	ura /	ack .			1 10 51	
Registr	ar	APK 1 2 200	b para s	3.	2000				

06-02385			Please Type	e or Print in l	Black Indelible Ink			
Taylor, Robert		State			Health and Mental H	lygiene	12 13 13 15	1 1 1 0 1
	F	l- For State Registrar		Certificate of	Death	Reg	. No. 2006	11483
Physician Medical Examine	-	1. Decedent's Name (First, Middle,La				2. Date of Death Month April 7, 200	Day Year	Time of Death 9:11
Weulcai Examine		Kobert D. IO' 4a Facility Name (if not institution, gi	y (D) ve street and number)	2	b. City, Town, or Location of Dea		4c. County of Death	
	ı	Johns Hopkins Hospital	, ,		Baltimore		NIA	
Funeral	7	5. Social Security Number 6. S	Sex 7. Age (II	n yrs. last birthday)	If Under 1 Year If Under 24H		(MM/DD/YYYY) 9. Birthp	
Director		217.52.5998 1	<b>X</b> M 2 F	56 Yrs.	Months Days Hours Mi	12.12	. 1944	""MD
<u>&gt;</u>		Usual Residence of Decedent  10a, State 10b, County	100	c. City, Town or Locati	00		1	0d Inside City Limits
ow any		Mn N/	4		more			1 Yes 2 No
irylanc ia-f.sh it onc	či	10e. Street and Number	•		10f. Zip Code	100	Citizen of What Countr	y?
eath with the Maryland items 23a or 28a-f show ust be notified at once.	<u> </u>	5209 GODIN	on Road	Apt. A	21204		USA	1
with 1 ms 23a be not		11. Marital Status	12. Was Decedent Eve	er in U.S. 13. Wa	s Decedent of Hispanic Origin? (		14 Race - America	n Indian, Black,
r death with or items 23 must be no	Ĕ	1 Never Married 2 Marrie	1 Yes 2		es, specify Cuban, Mexican, Puerl	o Rican, etc.)	White, etc.	
s after rall", niner	2		d If Yes, Give Year or Dates:	1	Yes 2 No specify:	work dono	Specify: Bld 16b. Kind of Business/Ind	(CL)
2 hour "natu Exan	rea	15. Decedent's Education (Specify Elementary/Secondary (0-12)	college (1-4 or 5+)	during	t's Usual Occupation (Give kind of vorking life. DO NOT use retired)	work done	_	21.
5-0036 ed within 72 hours lygiene other than "natu the Medical Exau	npie	12th avade	NA	O .	ritation Vuork	EV	Baltimor	re Cury
5-0( led wi Hygier other		17. Father's Name (First, Middle, Las	t)			ne (First, Middle, Ma	aiden Surname)	)
Fages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygins transition and file Table and Mental Hygins transition and the Health and Mental Hygins of Health and Mental Hygins of the Health and Mental Hygins or other traumatic event, the Medical Examiner must be notified at once To Bo Compilered by Erinaral Director	g	conese	layor		Ine	z Jone	<b>&gt;</b>	Zio Codel
MD 21 d 2 should th and Me n 27 is man umatic ev	2	19a Informant's Name/Relationship	/ Mother	196. Mailing	Address (Street and Number of	. 0		1218
a a ta u a		INCZ Taylor,	TYTOCHEY		ition (Name of cemetery,		20c. Location - City or To	
nore ages 1 nt of 1: other		1 Burial 2 Cremation 3		Crematory or oth	ner place)	4.13.00	Baltin	ove. MD
Baltimore, permit Pages I ar Department of He Important: If ite		4 Donation 5 Other Special Signature of Funeral Service Lice	•		ame and Address of Facility			
Bi II De la Co	ĺ	15からしっす		65 31	DOD E Baltin	one stree	X Batto. Fil	21224
Physician /Medical		23a Part I. Enter the disease or com failure. List only one cause on a		death. Do not enter the	ne mode of dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	Multiple Injuries					Death
1			Due to (or as a consequo.	ence or).				
100	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequ	ence of):				
	Examine	(Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequ	ence of):				
	_		d.					
be exe	ğ	UNPENDED	AMENDED					
box 68760, the death certificate be exect by the attending physician an orded for use as the burial - tr byveician/Modical	<b>M</b>	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of		tal death 3 Ectopic pregi	nancv	23d Date of delivery  Month Da	y Year
x 68 h certi tendin use a	<u> </u>	past 12 months?	4 Pregnant at tim		her (Specify)	,		,
Bo le deat the at ned for	Jys.	1 Yes 2 No 9 Unknow	9 OUKNOWN					
P.O.	oy L	Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	inderlying cause given in Part I.		acco use contribute to th 2 ✓ No 3 Proba	
duires quires en signald be						24a. Was ar		psy findings available
COTC law re has be	Completed					autops: perform	prior to con	mpletion of cause of
Re(	5				00 Blace of Beatly (Char	1 ✓ Yes 2	No 1 ✓ Yes	2 No
irector	ň	25. Was case referred to medical examiner?	Hospital: 1 ✓ Inpatient	2 ER/Outpatient	26.Place of Death (Chec		esidence 6 Other:	
of V g Phys fter thi	<u> </u>	1 ✓ Yes 2 No 27. Manner of Death	28a Date of Injury	28b. Time of li		28d. Describe ho	w injury occurred	
On ( ending sath. or: All the further	ition	1 Natural 5 Pending	Apr 6, 2006	22:45	1 Yes 2 ✔ No	Pedestrian st	ruck by auto	
Division of Vital Records, tat or Attending Physician: The law required is pairer death.  In Director: After this certificate has been sited in by the funeral director, page 2 should be defined in by the funeral director. Page Commissions afficiently.	THC	2 Accident Investigat 3 Suicide 6 Could no	ot be 28e. Place of Injury	/ - At home, farm, stree	et, factory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Rura	Route Number, City
Spital solurs a neral I filled	Certification:	4 Homicide determin	(Specify) Local	Street		5300 Blk Fra	nkford Ave, Baltim	ore, MD
		CHECK OTHY		-	red at the time, date and place, and the time, date and place, and the time, and the time.			
To t com	Medical	29b. Signature and title of certifier	and manner stated.		29c. License number		29d. Date signed (Mont	
1.5								

Zabiullah Ali, M.D. State 31. Date filed (Month, Day, Year) apstrar APR 1 2 2006

Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Aparla ORIGINAL

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

April 8, 2006

DHMH 17 Rev 1/2001 OCME 10/2003

Registrar

	-	For State Registrar	State of Maryland	d / Depa		of He	ealth a	nd Mei		eg. No.	006	3. Time of Death
Physic /Medi Exami	cal	^	rreet and number)	Cooler	0	4	Location of		Month Apy	Day	Year 200 County of Dé	56 843 PM
Funeral Director		5. Social Security Number 6. Sex 220-36-3243	Mand Medical ( 7. Age (In yrs. 1 67	ast birthday)			If Under 2 Hours	4 Hrs. 8. Min.	Date of Birth (Month, Day Oct 30	Year) , 1938	9. B	irthplace (State or Foreign Country) Maryland
Maryland I-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland N/		y, Town or L	ocation	Ba	altimore					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the	Director	10e. Street and Number 810 West Lexington Stre	et - #8		10f. Zip	Code	2120	)1		l 0g. Citiz	zen of What	Country? .S.A.
be filed within 72 hours after death with the Maryland ntal Hygiene.  Id other than "neture!, or items 23s or 28s-f show event, tre Mexical Examiner must be notified at	by Funeral		I2. Was Decedent Ever in U. Armed Forces? 1	S. 13.	Was Deced If Yes, spec		spanic Orig n, Mexican, Specify:	in? (Specifi Puerto Ric	y Yes or No- can, etc.)		14. Race - Ar Black, Wi Specify:	merican Indian, hite, etc. Black
within 72 hounde.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give	edent's Usua e kind of wo DO NOT us	rk done d se retired,	luring most			16b. Kii	nd of Busine	ss/Industry n Home
be filed tal Hygi d other event, I	To Be Co	12 17. Father's Name (First, Middle, Last) Harvey	Tiller	I						attie	Tiller	
and and is m		19a. Informant's Name/Relationship (Ty Evon Farmer Daughter	pe, Print)	19b. Mail	ling Address	(Street a	and Numbe	r or Rural F reet - #	Route Numbe 8 Baltimo	r, City o	r Town, State aryland 2	e, Zip Code) 1 <b>1201</b>
permit. Pages 1 and 2 should be filed within 72 hours all Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturel, or ery injury or other traumatic event, tra Medical Examinant Disce		20a. Method of Disposition  1  Surial 2  Cremation 3  4  Onation 5  Other (Specify)		_  Place of Disp cemetery, cre	osition (Nai	me of other plac	e)	Dat			cation - City	or Town, State re, Maryland
eath certificate be executed  Wedica attending physicien and for use as the burial-transit	cal Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a consect of the deal of the cause on each line.  Due to (or as a consect of the consect of the consect of the consect of the consect of the cause	quence of):	nter the mod		g, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death 2 Cay S
the d	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome of pregn 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of 6	al death 3	B⊟Ectopic p		/				23d. Date of Month	delivery Day Year
w requires that the solution of the solution o	d by Ph	Part II. Other significent conditions co	ntributing to death but not re-	sulting in the	underlying	cause giv	en in Part 1		23e. Did t			te to the cause of death?  Probably 4 DUnknown
The law requires table has been signed page 2 should be	Complete								24a. Was auto perfo 1 🗆 Yes		prior	
Physicien: Tribis certificational director, pa	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: Zinpatient 2	] ER/Outpati	ient 3□ D	OA Ott	000	of Death	(Check only only only only only only only only		6 ☐ Other (	Specify)
Attending r death. ector: Afte by the fune	Certification: To	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  2 Nordide	28a. Date of Injury (Month, Day Year)	28b. Time Injury	o of y M	28c. İnjur Wor 1 🗆	ry at rk?  Yes 2	No	8f. Location ( City or To	Street a	nd Number o	or Rural Route Number,
Hospital or 24 hours afte Funeral Dir etely filled in	edical Cer	29a. Certifier  (Check only one)  1X Certifying Phyone	vsician: To the best of my kn iner: On the basis of examin and manner stated.	nowledge, de nation and/or	eath occurre investigation	d at the tien, in my	me, date ar opinion, dea	nd place, a ath occurre	nd due to the	cause(s date an	s) and manne d place, and	er as stated. due to the cause(s)
To the within 2 To the comple	Mec	29b. Signature and title of certifier  30. Name and address of person who	List M	23g) (Tur		15	se number			4	or 6.	Month, Dey, Year) 2006
	State	31. Date filed (Month, Day, Year)	75 MI) 22 3. Registrar's Sign	S GO	eene	St	Balt	lmor	eM	> 2	21201	

DHMH 17 Rev 1/2001

			For State Registrar	State of Marylar	-	artment of H			iene	06	A Company	87
			1. Decedent's Name (First, Middle, Las	t)				2. Date of Deat	h Day	Year	3. Time of	Death
	Physicia		EDITH ELEAN	OR TOLLE	Y			April	9, 20	006	9:45	АМ
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of De	ath	4c. Co	unty of Death		
			7508 Kenlea Aven	ue			tingha			altimor		
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	,	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month, Day,			lace (State o	r Foreign
	Director		217-12-7663 Usual Residence of Decedent	93	Yrs.			oct. 4,19	912	Mary	land	
	and		10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				1	0d. Inside Ci	ity Limits
	Manyl f sho	ъ	Maryland Baltimo	<b>r</b> o	NZ	ottingham					1 🗌 Yes	2 <b>X</b> No
	the tage	Directo	Maryland Baltimo	ie	140	10f. Zip Code		1	0g. Citízen	of What Cour	ntry?	
	with 3a or	٥	7500 Venlee Arrens			21236			IInita	ed Stat	-OC	
	ns 2:	Funeral	7508 Kenlea Avenu	12. Was Decedent Ever in U	I.S. 13.		spanic Origin?	(Specify Yes or No- erto Rican, etc.)	14.	Race - Americ	an Indian,	
0	or Item	五	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 X No	1	n Yes, specny Cubar 1 □ Yes 2 🎇 No	Specify:	ento Fican, etc.)		Black, White,		
3	ral', c	þ	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		I⊟ 185 ZMINO	эрвспу.		Spi	ec <i>ify:</i> Wh	ite	
ק	filed within 72 hours after death with the Maryland Hyglene. ther than "natural", or Items 23s or 28s-f show that the Modical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Dece (Give	dent's Usual Occupa kind of work done d DO NOT use retired)	ation Juring most of w	vorking	16b. Kind o	of Business/In	dustry	
V	ithin ne.	ğμ	Elementary/Secondary (0-12)	College (1-4or 5+)			)		_			_
V	fed w fygier her ti		17. Father's Name (First, Middle, Last)	4	Tea	acher	18 Mother's N	ame (First, Middle, M		mentary	School	oT
2	l be findal Head of ed of	Be		177.0						,		
Š	should nd Men marke umatic	ဥ	Freeman Clyde B	ortner	19h Maili	no Address (Street a	Anne F	ULLET Rural Route Number	City or To	wn. State. Zip	Code)	
2	nd 2 si lith an 27 Is r r traur							Nottinghan			,	
ָר ע	1 a teg		Clyde Tolley, Son 20a. Method of Disposition	20b.	Place of Dispo	sition (Name of				ion - City or To	wn, State	
5	Pages nent of int: If it iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speqify	Removal from State		matory or other place ley Memorial		/12/06 11	monium	n, Maryla	Fore	
	artme artme ortan injury		21. Signature of Fundament Service Licen		-	2. Name and Addres		Brian T. Chi				z of
0	permit. Pages Department of H Important: If ite any injury or of		VIIIM MATA	MAN MITTE				00 Padonia F				
H			23a. Part1. Enter the disease, or comp	dications that caused the dea						<u> </u>	Approximat Interval Bet	e
	Physician /Medical Examiner		shock, or heart faflure. List only in mediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	a. ALZHE.  Due to (or as a consect		Dise	ASE				Onset and	Death
-	od iii	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence ot):					- 10		
	ate be executed hysician and the burial-transit	Examine	that initiated events resulting in death) Last	c	nuence of):							
Ď,	be ex cian burial			200 10 (01 00 0 001)	400.100 0.7.							
09/90	physic the l	dical		d								
O. Box	the death certificate be executed by the attending physician and ached for use as the buriat-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 DNo 9 ☐ Unknown	23c. If yes, outcome of pregn 1	aldeath 3[	□Ectopic pregnancy □ Other (specify)			23d.	. Date of delive Month		Year
coras, r	w requires that the de been signed by the s should be detached	þ	Part II. Dther significant conditions of	ontributing to death but not re-	sulting in the u	nderlying cause give	en in Part I.	23e. Did tot	. /	contribute to the lo 3 Prob	ne cause of c pably 4 □l	
eco	taw rec as bee 2 shor	Completed						24a. Was a	n 2	4b. Were auto	psy findings	available
r	9 4 9	E O						perforr	ned?	death?		ause or
VII	ı <b>lclan</b> : Th certificate rector, pag	a)	25. Was case referred to medical				26. Place of D	eath (Check only on				
	Physician: rthis certifica ral director, I	To B	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatie	nt 3 DOA Othe	er: 4 🗆 Nursing	Home 5 Reside	ence 6 🗆	Other (Specif	y)	
0	ding Ph J. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injury Work	at	28d. Describe ho	ow injury o	ccurred		
Ö	Attending ir death. ector: After by the fune	atic	2 Accident investigation				Yes 2 □ No					
DIVISION	r Atte er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, st	reet, factory, office		28f. Location (St City or Town	reet and N n, State)	lumber or Rum	al Route Num	ıber,
5	ital or rs aft all or a	Cer										
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medicel Exen	ysicien: To the best of my kn niner: On the basis of examin and manner stated.	owledge, deat ation and/or in	h occurred at the time execution, in my of	ne, date and pla pinion, death of	ice, and due to the ca curred at the time, d	ause(s) and ate and pla	d manner as s ace, and due to	tated. the cause(s	s)
	thin (thin (the orther	Mec	29b. Signature and title of certifier	and marrier states.		29c. License	number	2	9d. Date si	igned (Month,	Day, Year)	
	2 2 2 2		> compress	are MD		Di	6619		April	11,20	06	
	0)		30. Name and ad tress of person who	completed cause of death /lte	m 23a) (Tvne	Print)	,	DR. B.		·		
				PARES 994	O FRAV	UKCIN S	GUARE	DR. B.	SETTING	ORE, M	0.21	236
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign								
	Regist		APR 1 2 2006	Ragina &	- French	U						
DH	IMH 17 Rev 1/2	001		1	1							

DHMH 17 Rev 1/2001

ysiciar	n	1 - State Registrar  1. Decedent's Name (First, Middle				rtificate of	Death	2. Date of Month	Da	ıy Year	
ledica amine eral	r	5. Social Security Number	, give street and numb	APT	200 last birthday)	4b. City, Town,  BALT  If Under 1 Year  Months Days	MOLE If Under 24	Hrs. 8. Date of (Month,	Birth Day, Year	COUNT  9. Bi	ath
etor la palli		212-26-1321           Usual Residence of Decedent           10a. State         10b. County           MD         Balti		10c. Cit	Yrs. ty, Town or Lo wson	ecation		04/	07/19	928 MD	10d. Inside City Lit
edical Exacilner must be notified at	by Funeral Dire	1000 E. Joppa I  11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Decede Armed Force	ent Ever in U es?	1	10f. Zip Code 21286 Was Decedent of f Yes, specify Cub		i? (Specify Yes or Puerto Rican, etc.)	Un:	ited St  14. Race - Am  Black, Wh  Specify: Wh	ates nerican Indian, ite, etc.
		15. Decedent (Specify only highes Elementary/Secondary (0-12) 17. Father's Name (First, Middle, I	t grade completed) College (1-4	or 5+) <b>5+</b>	16a. Deced (Give life. L Homer	dent's Usual Occu kind of work done DO NOT use retire naker	during most o	f working  Name (First, Midd	Owi	Cind of Business n Home	
other treumatic event, ILE M	0	Gilbert Wilson  19a. Informant's Name/Relationsh Edward Wunder			1		and Number	ret Nola or Rural Route Nur Apt. 20	nber, City		
eny injury or other tre QDGE.		20a. Method of Disposition  1 □ Burial 2 □ Cremation  4 □ Donation 5 □ Other (Sc	pecify)	ate C	Place of Disponentery, cremiters, cremiters	sition (Name of natory or other pla ke Crema	tory In	Date Apr 1:	20c. L Bel	ocation City o	
		shock or heart failure. List			h Do not onte		Pastur				
ine burial-transit uer cal examiner	Ical Eva	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, learning to minimaliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	as a consequence as a c	uence of):  LTGV510  uence of):			rdiac or respiratory			Approximate interval Betwee Onset and Dea SUDDAN 1075ALS
cal ner	Ical Eva	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to minimodiate cause. Enter Underlying Cause (Disease or injury that initiated events	a	as a consequence of pregnant 2 = Fetal t at time of dr	uence of):  UTGUS!  Unance of):  SM (A  uence of):		ng, such as ca			23d. Date of de Month	Initiarval Batwae Onset and Dea SUDDSU 107824
should be detached for use as the buriar-transit.	by Filysicial miculcal Exa	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	a	as a consequence of pregnance 2 Fetal tat time of din	uence of):  UTGUS!  uence of):  SM (A  uence of):  uncy ideath 3    eath 5    ulting in the un	Ectopic pregnanci Other (specify)	ng, such as ca	23e. Di	d tobacco	Month use contribute t  PNo 3 □ P 24b. Were a	Interval Betwee Onset and Deat Sulvey  IOTSUS  IOTSUS  Blivery Day Year  to the cause of death Probably 4 Dunkney
should be detached for use as the buriar-transit.	De Completed by Finysicial Midelical Exa	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant condition	a	as a consequence of pregnan 2 Fetal tat time of done	uence of):  UTGUS!  uence of):  SM (A)  uence of):  incy ideath 5   ulting in the un	Ectopic pregnanc Other (specify) _ Iderlying cause give	y yen in Part I. 26. Place of	23e. Di 10 24a. Wi au pe 1   Yes	d tobacco Yes 2 as an topsy format? 2 No	Month use contribute t  □No 3 □ P  24b. Were a prior to death? 1 □ Yes	Interval Betwee Onset and Deal SUNDSU IOTSUS
by the Tuneral director, page 2 should be detached for use as the buriat-transit and control of the second	to be completed by rilystolate medical Exa	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to minimize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant condition  A L CO HOUSY  FEMPHORY  25. Was case referred to medical examiner?	a. Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outcoment of the latter of t	as a consequence of pregnance at a time of dinners of the but not rest at time of dinners of the but not rest at time of dinners of the but not rest at time of dinners of the but not rest at time of dinners of the but not rest at time of dinners of the but not rest at time of dinners of the but not rest at time of dinners of the but not rest at time of dinners of the but not rest at time of dinners of the but not rest at time of dinners of the but not rest.	uence of):  LTGS(I uence of):  L	Ectopic pregnance Other (specify)  Identifying cause grounds  3 DOA Other 28c. Injur Wor	y yen in Part I. 26. Place of	23e. Di 1[ 24a. Wi au pe 1   Yea Death (Check on) g Home 5 Are 28d. Describ	d tobacco Yes 2 as an topsy rformad? 2 No y one) sidence e how inju	Month  use contribute t  No 3 P  24b. Were a prior to death? 1 Vet  6 Other (Spery occurred	Interval Betwee Onset and Dea Sudden
should be detached for use as the buriar-transit.	regional Commission of the Completed by Figure 1 Medical Exa	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to minimalize cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condition  A L CU HOUSY  I WAS Case referred to medical examiner? 1   Yes 2   No  25. Was case referred to medical examiner? 1   Yes 2   No  27. Manney of Death 1   Natural   5   Pending investig: 3   Suicide   4   Homicide   Certifying	a. Due to (or b. Due to (or c. Due to (or d. 23c. If yes, outcoment of the latter of t	as a consequence of pregnance of pregnance at a time of drift of the but not result of t	wence of):  LTGUSI  LUDIOS OF):	Ectopic pregnance Other (specify)  Identying cause graderlying graderlying cause graderlying cause graderlying cause graderlying cause graderlying cause graderlying cause graderlying cause graderlying cause graderlying cause graderlying cause graderlying graderlying cause graderlyi	y  y  y  y  y  y  y  26. Place of  ner: 4 \( \) Nursi  y  x  Y  Y  Y  Y  Y  T  T  T  T  T  T  T  T	23e. Di 1[ 24a. William 1   Yes Death (Check on) 28d. Describ 28f. Location City or 7	d tobacco Yes 2 as an topsy formad? 2 No yone) sidence e how inju (Street ar own, State	Month  use contribute t  use contribute t  24b. Were a prior to death? 1   Yes  6   Other (Spery occurred	Initerval Between Onset and Deal SUNDSU IOTSUS IOTS

DHMH 17 Rev 1/2001

4/10/04 @ 9:15 Am

MARGARET WUNDER

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Weslen Eero 2006 6 4b. City, Town, or Location of Death 4c. County of Death Takuma Park If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 10b. County 10c. City, Town or Location

3 Time of Death Physician 14:22 PM Kichard /Medical 4a. Facility Name (If not institution, give street and number) Examiner Montgomery

9. Birthplace (State of Foreign
Country)

5. State of Foreign Washington Adventist Hospital

5. Social Security Number 6. Sex 7. Age (In yrs. last birth **Funeral** 364-54-5588 Director minnesota Usual Residence of Decedent 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-1 show any injury or other traumatic event, the Marical Examinar Cleveland 1 ☐ Yes 2 No GA White Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 30528 USA 168 Head Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2000 Specify. Specify: White ģ 3 ☐ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be illian Matara Giles Wesley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lois Hill/Sister 30528 168 Head St. Cleveland, GA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 remation 3 Removal from State 4-8-06 hesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rapp Funeral + Cremation Services 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consec Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a neral Director; After this certificate has been signed by the attending physician filled in y the timeral director, page 2 should be detached for use as the buria Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 ☐ Probably 4 ☑Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to examiner? 26. Place of Death |Check only one Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier (Check onl

レイルレミイ カ ルと Division of Vital Records, P.O. Box 68760, within 24 hours a To the Funeral L o the Hospitel

1 - For State Registra

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 619 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 76/0Carroll Ave. Takoma Park, MD 20912 32 Registrar's Signal to 2 2006

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	State of Ma		partment of F ertificate of			eg. No.	16	1490
	Dhysioi	×	Decedent's Name (First, Middle, Last	t)				2. Date of Dea Month	th Day	Year	3. Time of Death
7	Physici /Medio		MARILYN WIL	SON				4	7	06	1:03 A M
	Examir		4a. Facility Name (If not institution, give				r Location of Deat		4c. Count	of Death	
			UNIVERSITY of MARY	LAND MEDIC	AL CENTER	ISAC	TIMONE				
	uneral		Social Security Number     6. Se	7. Age	(In yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Day	Year)	9. Birthp	ace (State or Foreign
D	irector		225-72-2802	M 2KNF	7 Yrs.		110070	Dec. 1,	1948		VA
p	>		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Lacation					
aryla	ehor m	_	,							1	0d. Inside City Limits 1 ☑ Yes 2 ☐ No
₩	- 88-	octo	MD Baltimo	re	Randal						
vith t	or 2	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cour	itry?
ath v	230	Funerai	3708 Stoney Broo			21133			USA		
ar de	te m	nue	11. Marital Status	12. Was Decedent Example Forces?		<ol> <li>Was Decedent of H If Yes, specify Cuba</li> </ol>	lispanic Origin? (S an, Mexican, Puerl	Specify Yes or No- to Rican, etc.)		ce - Americ ck, White,	
36 s afte	0,	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🕱 No If Yes, Give	•	1 ☐ Yes 2 🖾 No	Specify:		Specia	y: Bla	ıck
:1215-0036 within 72 hours after death with the Maryland	ural E	d b		Year or Dates:	1 42 2						
21215-0036 ad within 72 hours aft	u H	Completed	15. Decedent's Edu (Specify only highest grad		(Gi	edent's Usual Occup ve kind of work done . DO NOT use retired	during most of wor	rking	16b. Kind of B	usiness/in	dustry
With La	than than	m	Elementary/Secondary (0-12)	College (1-4or 5+	)	nestic	2)		Homem	akor	
C D	it it		17. Father's Name (First, Middle, Last)		1 1001	lestic	18 Mother's Nar	me (First, Middle, I			
and and and and and and and and and and	o d o	Be								,	
P bout	nark nati	ဥ	George Crittende: 19a. Informant's Name/Refationship (T)		19h Ma	iling Address (Street		G. Hamilt		Ctata Zia	Codel
Maryland	7 ie 7 ie trau		Joseph S. Wilson,			Stoney B				2113	
, - and	em 2 the	1 3	20a. Method of Disposition	DI • / Husba	20b. Place of Dis	position (Name of			20c. Location		
altimore,	Department or result and wenter tygiene.  Department of result and wenter tygiene.  By injury or other traumatic event, the Mudical Examinar must be notified at ance.		1 ⊠ Burial 2 ☐ Cremation 3 ☐ F		cemetery, c	ematory or other place	al / 1				
<b>tin</b>	njury		4 Donation 5 Other (Specify)		Snenand	oah Park			Winches		
Bal	mpo my i		21. Signature of Funeral Service Licens	1		22. Name and Addre		Cartwrigh		сат но	ome
	Sicro		Deminu O	ewner				lincheste			
T- A			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ne cause on each line	).				est,		Approximate Interval Between Onset and Death
, .	sician		fmmediate Cause (Final disease or condition resulting in death)	a. INTRA	CEREBRA	L HEMO	MA HAGE	5	N	NER	Shock and Boath
	ledical aminer		resulting in death)	Due to (or as a	consequence of):			4	W CHI	W.	
-94	4-	Ļ	Sequentially list conditions,	b. FALL	consequence of):			V	CAL		
1/8	sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or):				BAMA		
V in	and I-tran	хап	that initiated events resulting in death) Last	C. Due to (or as a	consequence of):			in land	>	-	
60,	cian			200 10 (01 43 4	consequence on.			1014 11			
68760, ificate be executed	physician and s the burial-transit	edicai		d				TIFER			
<b>U</b>	ding se as		IF FEMALE:	23c. If yes, outcome of	i oragonana.			CZ			
. Box	attending I tor use as	Physician/M	in the past 12 months?	1□Live birth 2	Fetal death	□Ectopic pregnancy	•			te of delive onth	ry Dav Y <i>e</i> ar
P.O.	the	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me or death :	Other (specify)					
	ed by the a detached t		Part If. Other significant conditions co	otobuting to death but	not resulting in the	underlying cause giv	en in Part f	23e Did tot	Dacco usa con	tribute to th	e cause of death?
Division of Vital Records, to Attending Physicien: The law requires talence death	5.5	1 by	•			and onlying sauso gre	on an earth				ably 4 □Unknown
0.00	been s	Completed									
e ta	200	ig.						24a. Was a autops	V	prior to cor	osy findings available inpletion of cause of
	oag Dag	ပ္ပ						perform 1 ☐ Yes 2	ned?	death? 1 □ Yes	2 □ No
/ita	certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Dea	ath Check only on	θ)		
Tys is	his c	ို	Yes 2□ No	Hospitaf: 1 🗷 Inpatient		ent 3 DOA Oth	er: 4 ☐ Nursing H	lome 5□Reside	nce 6 Oth	er (Specify	)
n o	After thi	ü	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day		Worl	y at k?	28d. Describe ho	w injury occur	red	
Sind in	or: A	att	2 Accident investigation	3-27-06	2110	DPM 10	Yes 2 No	subject	.fell		
Y AH	rect.	ertification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, (Specify)	street, factory, office		28f. Location (St. City or Town	reet and Numb	er or Rura	ney brook Rd
Division of Vital To the Hospital or Attending Physicien:	within 24 floors after deak To the Funerel Director: completely tilled in by the	O			At	home		Kandall S	town	her	)
idsol	une Bly til	edical	29a. Certifier Certifying Phy	sician: To the best of	my knowledge, de	ath occurred at the tin	ne, date and place	e, and due to the ca	use(s) and ma	anner as st	ated.
the F	the f	led		and manner state	ed.						
2 t 3	100 COU	Σ	29b. Signature and title of certifier			29c. License		29	9d. Date signe	d (Month, I	Day, Year)
			Nil M	. 6.		P19	672		4171	06	
	10		30. Name and address of person who co	ompleted cause of dea	ith (Item 23a) (Typ	e, Print)		1	1 1	1.1	010 3
	W		JOSEPH D. CM	TIND	705 5	BETHE	C 57.	BACTI	nort	MIS.	21431
	Sta Registr		31. Date filed (Month, Day, Year) APR 1 2, 200	3 Registrar	s Signature	artes			/		

			1 - For State Registrar	State of Maryland			of Health and of Death	•	giene	06	- Command
F	Physici /Medi		1. Decedent's Name (First, Middle, Las Marie E, Williams					2. Date of De Month 04	Day	Year 006	3. Time of Death 9:00 AM M
	Examir	ier	4a. Facility Name (If not institution, give 8110 Bradshaw Roa 5. Social Security Number 6. Se	đ	t birthday)		vn, or Location of De SVILLE ear I If Under 24 F		4c. County	timor	
Di	uneral rector		213-44-9286 Usual Residence of Decedent	□M 2\\ F 61	Yrs.	Months Da		8. Date of Bir (Month, Da 04/12/			ace (State or Foreign try)
death with the Maryland	28a-t ehow	rector	10a. State 10b. County  MD Baltimo  10e. Street and Number		Town or Lo ngsvi]		de		10g. Citizen of V		Od. Inside City Limits 1 ☐ Yes 2 ▼ No
5-0036 72 hours atter death with	ai', or iteme 23a or 28a-t ehov Examinar must be notified at	by Funeral Director	8110 Bradshaw Ro  11. Marital Status  1 Never Married 2 Married 3 XMidowed 4 Divorced	ad  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes. 2 ▼No If Yes, Give Year or Dates:		210	87 of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	U.S.A	e - America ck, White, e	an I <i>n</i> dian, etc.
d 21215-0036 filed within 72 hours after Hygiene.	d other then "natural", event, the Medical Exa	Completed	15. Decedent's Ed. (Specify only highest grad Elementary/Secondary (0-12)	de completed)  College (1-4or 5+)	(Give life. L	lent's Usual Do kind of work do DO NOT use re	one during most of voitined)  Driver	•	Baltimo: School	re Co Syste	unty
arylan should be nd Mental	7 is marked oth traumatic even	To Be	17. Father's Name (First, Middle, Last)  Millard R. Schro  19a. Informant's Name/Relationship (T)		19b. Mailin	g Address (Str		lame (First, Middle, ia Kowall Rural Route Numbe			Cade)
of Hea	f Item 27 ir other tr		Jane C. Harvey  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ F	(cousin)	144 e of Dispos		Oak Drive			ida	32666
tim trent	Important: any injury o once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	Holly	22.		Gdns. 04 Idress of Facility E lair Road		hn Fune:	ral H	ome, P.A.
/Me Exar	cicien and prize transit miner	Examiner	23a. Part1. Enter the disease, or complements of the control of th	a. Due to (or as a consequent Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a) Due to (or a	rice of):		dying, such as card		rrest,		Approximate Interval Between Onset and Death L. WWW.M.J.C.
. Box 687	by the ettending phys ached for use as the	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d	ath 3 🗆	Ectopic pregna Other <i>(specify</i>			23d. Date Mor	e of deliven	y Day Year
ords, P.O	been signed should be det	∣র	Part II. Other significant conditions con	ntribufing to death but not resulfin	ng in the un	derlying cause	given in Part I.	23e. Did to	obacco use confr es 2 PNo		cause of death?
al Rec	page 2	Completed							sy p	rior to com eath?	sy findings available pletion of cause of
Division of Vital Records, for Attending Physicien: The law requirest effer death.	Sid i	2 B	27. Manner of Death  1 Naturat 5 Pending 2 Accident investigation		/Outpatient b. Time of Injury	28c. Ir	O++	eath (Check only of Home 5 Resid			
DIVIS	filled in by t	il Certification:	3 Suicide 4 Homicide  6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)				City or Tow			
To the Hospital	completely	Medical	one)	sician: To the best of my knowled ner: On the basis of examination and manner stated.	and/or inve	estigation, in m	ny opinion, death oc	curred at the time, o	late and place, a	nd due to t	he cause(s)
1	0		30. Name and address of person who co			rint) Roac	1#208	, Baldi	wore,	no	21236
R	Stat Registra	~	31. Date filed (Month, Day, Year) APR 1 2 20	32/Registrar's Signature		all s					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year 08 1:50 AM<sup>M</sup> Earl Albert Winters 04 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson, Maryland
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Baltimore Gilchrist Center 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 11XM 2□ F 11/22/1918 Director 87 168-16-2753 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits rthan "natural", or Items 23a or 28a-f shov Ita Medical Examiner must be notified at Baltimore Middle River 1 ☐ Yes 21 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1103 Middleway Road Apt. 2A 21220 U.S.A. deeth \_ 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Tes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛛 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) 6 Custodian School System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Samuel Henry Winters Alice Gean Burton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Pages 1 and 2 ment of Health a ant: If Item 27 Is ury or other trai Earl Winters (son) 1701 Ingleside Road Forest Hill, Maryland 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State pernit. Page Deportment o Important: If any injury or once 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gdns. 04/13/2006 Baltimore, Maryland 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 21. Signature of Funeral Service Licensee assalw 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Septicemia days /Medical Due to (or as a consequence of): Examiner Aspiration Precuonia Jazs J Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical attending phase of the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Osstruthe Long disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ₩ No has 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Medical Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Hospitel or Attending 5 Pending investigation 1 Natural Injury efter death. 1 ☐ Yes 2 ☐ No 2 Accident the 3 Suicide 6 Could not be within 24 hours efter de To the Funeral Directo completely filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00061199 Mas April 8. 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Charles ST, Touson MD 21204 Black 6607

State

Registrar

31. Date filed (Month, Day, Year)

APR 1 2 2006

Baltimore, Maryland 21215-0036

68760,

of Vital Records, P.O.

**Division** 

32. Registrar's Signature

			For 1_ State	State of M	laryland /	*			d Mental H		Onna.	11100
			Registrar  1. Decedent's Name (First, Middle, L	2011		Certi	ficate of L	Jeani	2. Date of D	Reg. No	2000	3. Time of Death
· ·	Physici	an	<b>1</b>		VII 1. (	")			Month Acc. 1	Da		80:12M
	/Medic		4a. Facility Name (If not institution, g		7/LAND		lb. City, Town, or	Location of E	10 1	4c	. County of Death	
1500	Examili	ei		1Ar/Ino 1	Mederal (	onle	Baltimore	(L)			n MA	-
4	Funeral		Social Security Number 6.	Sex 7. A	ge (In yrs. last b	i bridaly /	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of B	irth Dav. Year	9. Birthi	place (State or Foreign
×	Director		212-26-2238	1□M <b>¾</b>	8	<b>4</b> rs.			Min. 2-1-2	22	PA	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	wn or Loca	tion					10d. Inside City Limits
	Maryl f sho	to	MD		Ba	ltim	ore					1¶Yes 2□No
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Ci	tizen of What Cou	ntry?
	h with	a D	106 S. Stockt	on Stree	t		21223	3		U.S	. A .	
	deat	ner	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Wa	as Decedent of Hi	spanic Origin n, Mexican, P	? (Specify Yes or Note of Puerto Rican, etc.)		14. Race - Ameri Black, White,	
36	or It	by Funeral	1 Never Married 2 Married	If Yes, Give	No		Yes XXVo	Specify:			Specify: Wh	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. Whet then "natural", or lieme 23a or 28a-f show with the Madical Examination must be notified at	ed b	3 Widowed 4 □ Divorced  15. Decedent's	Year or Dates:		Deceder	nt's Usual Occupa	ation		16b K	(ind of Business/In	
7.	in 72 in 72	Completed	(Specify only highest g	rade completed)		(Give kir	nd of work done a NOT use retired,	furing most of	f working	100.11	and of Dasinosam	oddii y
212	d with jiene.	E o	Elementary/Secondary (0-12)	College (1-4or	5+)	Hom	ecare_			Nu	rsina	
	e file at Hyg othe vent,	Bec	17. Father's Name (First, Middle, Las	st)				18. Mother's	Name (First, Midd			
<u>yla</u>	should be and Mental I smarked o	10	John Hannah						zel (un.			
Maryland	C/ 42		19a. Informant's Name/Relationship			,			or Rural Route Num	. ,		Code)
	1 and Health em 27 ther tr		May Beamsderfe				ion (Name of	St. I	Balto. M	1	I 2 2 4 ocation - City or To	own State
Baltimore,	permit. Pages Department of Inportant: If Ite any injury or of		1 ☐ Burial 2 ☑ Cremation 3	☐Removal from State	cemete	ery, crema	tory or other place Crem.		-12-06	10	ndalk,M	
풀	artme artme ortant injury		4 □ Donation 5 □ Other (Special Service Lice		1				Wesley	_		
Ba	permit. Departr Importa eny inji		1 /N lolas	Mar	h				Ave. Bal			
.3	. # # # ·		23a. Part1. Enter the disease or co shock, or heart failure. List on	mplications that cause	ed the death. Do							Approximate Interval Between
9	Physician		Immediate Cause (Final disease or condition		CORAL							Onset and Death
1	/Medical		resulting in death)		s a consequence	e of):	de m	FILA				
Н	Examiner		Sequentially list conditions		esnal	5	don	A				
	pe #is	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a:	s a consequence		. —		ron		741	
	and and II-tran	хап	that initiated events resulting in death) Last	c. Due to (or as	s a consequence	L 2 A ∋ of):	1 +1	KALO?	re in	ni:	I TOTAL DISC	
8760,	eath certificate be executed attending physician and for use as the burial-transit	dlcal E		4								
687	ifficate g phy as the	edic		u				-		- 1		
Вох	death certific e attending p id for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregnancy 2  Fetal deat	h 3∏E	ctopic pregnancy				23d. Date of deliv	
	0 0	sicis	in the past 12 months?		at time of death		Other (specify)				Month	Day Year
P.0	at the	Phy	9 Unknown		hut out convibion	in the cond		on in Dani I	220 Dic	Ltobasco	uca contributa to t	he cause of death?
Ś	The law requires that the de ate has been signed by the bage 2 should be detached		Part II. Other significant conditions	contributing to death	but not resulting	in the und	eriying cause give	en in Parti.		Yes 2		
Vital Record	requ	Completed										
Rec	as as as	mpi							— 24a. Wa aut per	topsy formed2	prior to co	opsy findings available ompletion of cause of
a		မ င	25. Was case referred to medical					26 Place of	1 ☐ Yes i Death (Check only	/	1 Tes	2 No
>		To B	examiner? 1 ☐ Yes 2 Z No	Hospital: 1 Inpat	ient 2□ER/C	utpatient	3□ DOA Othe	20	ing Home 5 Re		6 ☐Other (Speci	fv)
ا م	g Ph ter th		27. Manner of Seath  1 ✓ Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 28b.	. Time of Injury	28c. Injury Work		28d. Describ			
Sior	Attending r death. ector: After by the fune	atlc	2 Accident investigat	ion		,,		Yes 2 □ No				
Division	or Attuiter de Directe in by t	Certification:	3 Suicide 6 Could not 4 Homicide determine	286. Place of II	njury - At home, t etc. <i>(Specify)</i>	farm, stree	t, factory, office			(Street al own, Stat	nd Number or Run e)	al Route Number,
	Hospitel of the hours at Funerel D		29a, Certifier 1 Certifying	Dhusiaian T. H. L.	A = 4 mm · 1 m · · · · t = d ·							
	24 ho 24 ho Fun etely (	edicai	(Check only 2 Medical Ex	Physician: To the bes aminer: On the basis and manner s	of examination a	ge, death d ind/or inve	stigation, in my of	oinion, death	occurred at the time	e, date an	d place, and due t	o the cause(s)
	To the Hospitel or Attending Phys within 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral director.	Me	29b. Signature and title of centiler				29c. License	number		29d. Da	ate signed (Month,	Day, Year)
	- 3 et 0		> 111. X C	1	. MV	)	AUGITH	43511	124101	A01	71 /0	2006
	1		30. Name and address of person wh	completed cause of	death (Item 23a)	) (Type, Pr				0		2006 No,2/26/
	.0		Michae T	KOUT		2	South	Be	ene st,	GAI	timore 1	NO, 2/201
43/3	Sta		31. Date filed (Month, Day, Year)	200	trar's Signature	Bank	AL.					
	Regist	al	APR 1 2	2006	the Sa	5						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Williams Month Year 41 PM Croestine 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Taki HOSPITAL 117 5. Social Security Number 213-68-812 6 If Under 1 Year | If Under 24 Hrs. 6. Sex 4 7. Age (In yes last birthday) **Funeral** Days 1□M 2XF Yrs. Director Usual Residence of Decedent 10a. State 10b. Count 10c. City. Town or Location 10d. Inside City Limits 28a-f show and Mental Hygiene. Is marked other then "nature!, or Items 23s or 28s-f shov raumatic event, the Medical Examiner rount by notified at 1 XYes 2 □ No Maryland

10e. Street and Number Director more 10f. Zip Code 10g. Citizen of What Country? Funerai Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be rances 19a. Info to t's Name/Relationship (Type, Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth a Importent: If Itsm 27 is any injury or other training once. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility 21. Signature of Funeral Service Licensee Joseph Ly Kus 2222 W. North 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tighture. List only one cause on each line. Approximate Interval Between Onset and Death Physician Stroke week disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Endocarditis Value well Aortic Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attending Physician: The law requires that the deeth certificate be executed the attending physicien and hed for use as the burial-transit Failure Renal Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, 10 4000 erterion Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à cete has been sig page 2 should b 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 1 Yes 2 No Medical Certification; To 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural
2 Accident 5 Pending 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jenne Goldbers, John Hopkins Hospital Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U Certificate of Death 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle Last) **Physician** 12:10p M William Leslie Armiger, Jr. 4-8-2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Atlantic General Hospital Worcester Berlin If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12-13-1931 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1₹3M 2∏ F Yrs. 218-26-7937 MD 74 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County worde! r than "natural", or Iteme 23a or 28a-f ehov the Medical Exeminer must be notified at 1 ☐ Yes 2 ☒ No Director MD Worcester Ocean City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 719 Loop Road U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12√1 Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 20XMarried Specify: white 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Line Repairman Telephone Company s 1 and 2 should be filed v t Health and Mental Hygie Itam 27 Is marked other t other traumatic event, ID Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Leslie Armiger, Sr. Alice L. Disney 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important: If Itam 27 Is any Injury or other trau Mrs. Nancy Armiger / wife 719 Loop Road; Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 XBurial \_2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 4-12-2006 Brooklyn Park, MD Dopation 5 Dether (Specify) 22. Name and Address of Facility Singleton Funeral Home, PA Funer S wer Licensee M0136 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician ASCVO /Medical Due to (or as a consequence of): Examiner raillinsms Sequentially list conditions, it any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physicien and the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No autopsy performed2 certificete 1 Yes 2 No Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death | Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes = 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this c o 20 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 Pending Th death. investigation Director: , 6 Could not be determined 3 ☐ Suicide 26 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier N (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier HO053714 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mutzeni Ave Sute 302 Bencin MO 314 Frankin 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Willia

miger

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27, perML, 9554,4/15/06 IT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Yeer **Physician** 2006 23, 10:17 Tanya Apson February /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months unk 1 ☐ M 2 ☑ F 49 Yrs unk 30, Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County r then "natural", or items 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1801 Wentworth Avenue USA 21234 death by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white Year or Dates: Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working unk life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education unk (Specify only highest grade completed) other then Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk unk Pages 1 and 2 should be nent of Health and Mental 27 is marked of treumatic ever ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: if item 27 is eny injury or other treuonce. O.C.M.E. 111 Penn Street Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State `4 □Donation 5 🖾 Other (Specify) in State permit. 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Funeral Service Rollald Director mule mar Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) Physician Hypertensive cardiovascular disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine anding physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetef death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? jo 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown peen : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 2 No 17 Yes 2 No 11X Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 □ No 1 fnpatient 2X ER/Outpatient 3 DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of After fnjury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation death. after death in by the 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours a To the Funeral L Hospital pellil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier O.C.M.E. February 24, 2006 30. Name and address of person who completed cause of death (from 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201 M.D. Theodore M. King,

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year 550 **Physician** a M 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Yospital Baltimore Greneral Jak 4/and 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign **Funeral** Days Hours Min 1 M M 2 ☐ F 179-22-3145 Usual Residence of Decedent Yrs. Director lorida 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28e-f show treumetic event, the Medical Examiner must be notified at Maryland 1 XYes 2 ☐ No **Funeral Director** timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ Items 23g ld on 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. perrit. Pages 1 and 2 should be filed within 72 hours atter of Department of Health and Mental Hygiene. 1 Never Married 2 Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Completed by 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is marked other then Elementary/Secondary (0-12) College (1-4or 5+) e 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant Name/Relationship (Type, Print) SIS 7-in-b. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1209 Impartent: If item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or 4 ☐ Donation 5 ☐ Other (Specify) and Address of Facility 21. Signature of Funeral Service Licensee Russ Funeral Home, P. A North Ave, Balton Md. 2 any ther the disease, or complications that caused the death. Do not enter the or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed /XR Due to (or as a consequence of): burial Box 68760 IF FEMALE: 980 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) P.O. the 9□ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 3 Probably 4 dunknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 2 No Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: fo the Hospitel or Attending Division 1 Natural 2 Accident Injury 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Thomicide within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and 29c. License number 29d., Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) Type, Print)

State Registrar 32. Registrar's Signature

10	1	For State Registrar		ryland / Dep		te of De		R	leg. No. U U E	11100
Physician		. Decedent's Name (First, Middle, Las		D	uld.			2. Date of Dea Month	Day Ye	3. Time of Death
/Medical	١.		ona	Byczynsl				April 8		4:45 P
Examiner	4	a. Facility Name (If not institution, give				y, Town, or Lo		h	4c. County of	
		Stella Maris Hos		the way to at high de-		imonium	Under 24 Hrs	Lo Di (Biri		more Co.
uneral rector		. Social Security Number 6. S. 217–68–1061	DM 213/F	(In yrs. last birthda 75	Month		lours Min.			Birthplace (State or Fore Country) Iaryland
show	1	0a. State 10b. County	timore	10c. City, Town or	Location		Dunda	 1ኔ		10d. Inside City Lim
rel', or items 23a or 28a-f show Examinar must be notified at the Funeral Director	Direct	Oe. Street and Number	CIMOTE		10f. 2	Zip Code	Dunga		0g. Citizen of Wha	
23a	L	1211 Delbert Av	e				212	22	United	States
or Items 23s	1	1. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	3. Was Dec	edent of Hispa	nic Origin? (S	Specify Yes or No- to Rican, etc.)	14. Race -	American Indian, White, etc.
Examin Framin f by Fu		1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 N If Yes, Give Year or Dates:				pecify:	, 2121,	Specify:	White
7 is marked other than "naturel", of traumatic event, the Mudical Exert traumatic event, the Mudical Exert traumatic event, the Modelle Exert traumatic even		15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dec	cedent's Us	sual Occupation work done during use retired)	n ng most of wo	rking	16b. Kind of Busin	ess/Industry
than dring	•	Elementary/Secondary (0-12)	College (1-4or 5-	-)					NT / 70	
1 0 0 E	1	None 7. Father's Name (First, Middle, Last)		L	Disab.		Mother's Nar	me (First, Middle, i	N/A	
Be Be						10.				
그 말		John Byczynski		401.14		10:		hine Stop	-	
tem 27 is rother traur		9a. Informant's Name/Relationship (1 Patricia M. Prete		er 121	ll Del	lbert A		undalk, I	r, City or Town, Sta Maryland	21222
등	2	0a. Method of Disposition		20b. Place of Dis	position (N	ame of other place)	ì	Date	20c. Location - Cit	y or Town, State
יין אַנ אַני אַני		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Holy Ros	-		v 4/12	/2006	Dundalk	, Maryland
Important: If Item 27 is marke any injury or other traumatic once.	2	21. Signature of Funeral Service Licen			22. Name : Du	and Address of Ruck F	Facility uneral	Home of	Dundalk,	Inc.
		2 P. Enter he disease, or comp shock, or heart failure. List only	WXX						Maryland	21222 Approximate
he burial-transit apply the burial-transit apply apply the burial-transit apply appl		esulting in death)  Sequentially list conditions, any, leading to immediate ause. Enter Underlying ause. Enters of injury hat initiated events esulting in death) Last	b. Due to (or as a	consequence of):	DIJIA					
ysicie ie bur cal			d.	. consequence of);						
e as th	1	F FEMALE:								1
nd by the ettending phases to the detending phases the detached for use as the physician/Medi	2	3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	B⊟Ectopic B⊟ Other (s				23d. Date of Month	f delivery Day Year
be be	11	art II. Other significant conditions co	ontributing to death bu	t not resulting in the	underlying	cause given in	Part I.			te to the cause of death?
should should	ŀ		<u> </u>					24a. Was a		Probably 4X Unkno
r, page 2 should								autops perform 1 Yes 2	y prior deat	to completion of cause
rector, p		5. Was case referred to medical examiner?	Hospital:			Other		ath Check only on	-51	TO COT C
this cral dire	2	1 ☐ Yes 2 📉 No.  7. Manner of Death		t 2 ER/Outpati			4 ☐ Nursing F		ence 6XOther (	Specify) HOSPIC
he funer atlon:	-	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		Year) Injury		28c. Injury at Work? 1 ☐ Yes	2 🗆 No	260. Describe no	ow injury occurred	
el Director: Atter ed in by the funera Certification:		3 Suicide 6 Could not be								r Rural Route Number,
ly lill	2	9a. Certifier X Certifying Physics (Check only one) 2 Medical Example 2	ysician: To the best o liner: On the basis of and manner stat	f my knowledge, de examination and/or ed.	ath occurre investigation	d at the time, o	date and place on, death occu	a, and due to the caurred at the time, do	ause(s) and manne ate and place, and	or as stated. due to the cause(s)
9 5		01.00			2	9c. License nu	mber	2	9d. Date signed (N	fonth, Day, Year)
completely lii	2	9b. Signature and title of certifier			1					
complete	2	9b. Signature and time of certifier				D47	22		4/101	106
To the Funeral Direct completely litled in by Medical Certifi		Signature and tipe of certifier      Name and address of person who certifier	on he seuso betalamos	ath (Item 23a) (Turn	e. Print\	D43	725		4/10/	106

DHMH 17 Rev 1/2001

APRIL 8, 2006 4:45 p.m.

LEONA BYCZYNSKI

### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

2006 1149	1
-----------	---

	hysician/ Examiner
$\bigcirc$	

Funeral Director

permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Baltimore, MD 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physicians: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunial - transit

The Depart of Name (First, Missel, Last)  EDWARD D. BLUE  4. Enable Name (First Institution, oy we streat are number)  Beat Check Private at 2019 Paulited Road  Dundalk  Dundalk  Soon Security Number  6. Soon Security Num	Registrar	Certificate of D		Reg. No	D.	a Time of Dooth
BEUTARD D. BLUE  As secolly tarved or insulfactor, give steel and namely  Bear Creek River at 2019 Paulette Road  2.14 - 5.3 - 3.0.79  1.3	Decedent's Name (First, Middle,Last)		1	Month Day	Year	3. Time of Death
As Secular Security Number 6 on Security Number 6 of Security Number 6 of Security Number 6 of Security Number 6 of Security Number 6 of Security Number 6 of Security Number 6 of Security Number 6 of Security Number 6 of Security Number 6 of Security Number 7 of Security Number 7 of Security Number 7 of Security Number 7 of Security Number 7 of Security Number 7 of Security Number 7 of Security Number 7 of Security Number 7 of Security Number 7 of Security Number 7 of Security Number 7 of Security Number 7 of Security Number 7 of Security Number 7 of Security Number 8 o	EDWARD D BLUE			April 10, 2006		
Beat Creek River at 2013 Paulette Road  7. Age (in yes last before)  10. Serial Sealory Manner  10. Se	4a. Facility Name (if not institution, give street and number	r) 4b. (	City, Town, or Location of Death			
\$ Social Security Number    Social Security Number   Social Security Nu			undalk		Baltimore Co	unty
The control of the	the second secon	1	FUnder 1 Year If Under 24Hrs.	8. Date of Birth (MI	M/DD/YYYY) 9 Bit	rthplace (State or Foreign
The state and Number	o, ocola, ocoany name	-			1008	ountry)
Too. State of the County MD BALTIMORE  DUNDALK  10: Stated and Number  2009 PAULETTE ROAD  12 Was December Ever in U.S.  13 New December of Higher Configure Congress of West Country?  15 December's Encarion (Spectly oil) playing and completion in the state of the s	214-53-30/9 1 MM 2 F	Yrs.		01750	( )	IARYLAND
The Carry No. State   10c. Carry No.	Usual Residence of Decedent					10d Inside City Limits
MD BALTIFURE 107. Street in Number 107. Street on Number 107. Street in Number 107. Street in Number 107. Street in Number 107. Street in Number 107. Street Number 1	10a. State 10b. County					
100. Street and Number 2 009 PAULETTE ROAD 2 1222 1 Will Specify USA 1 Mantal Status 1 Martin Status 2 Married Country 1 L West Decodent Ever in US 1 Minor Martin 2 Married 2 Married Country 1 L West Decodent Ever in US 1 Minor Martin 2 Married 2 Married Country 1 L West Decodent Ever in US 1 Minor Martin 2 Married 2 Married Country 1 L West Decodent Status 1 L West Decodent of Hispanic Origin? (Specify Yes or Notice Hammar Country) 1 L Yes 2 L West Decodent of Hispanic Origin? (Specify Yes or Notice Hammar Country) 2 Martin Status 3 Martin Status 3 Ma	MD BALTIMORE	DUNDALK				1 Yes 2 NNo
2009 PAULETTE ROAD 11 Metric Status 12 Mero Excelent Ever in U.S. 13 West Decedent Full Metric Status 15 Decedent's Education (Specify only highest grade completed) 15 Decedent's Education (Specify only highest grade completed) 15 Decedent's Education (Specify only highest grade completed) 15 Decedent's Education (Specify only highest grade completed) 15 Decedent's Education (Specify only highest grade completed) 15 Decedent's Education (Specify only highest grade completed) 15 Decedent's Education (Specify only highest grade completed) 15 Decedent's Education (Specify only highest grade completed) 15 Decedent's Education (Specify only highest grade completed) 15 Decedent's Education (Specify only highest grade completed) 15 Decedent's Education (Specify only highest grade completed) 15 Decedent's Education (Specify only highest grade completed) 15 Decedent's Education (Specify only highest grade completed) 15 Decedent's Education (Specify only highest grade completed) 15 Decedent's Education (Specify only highest grade completed) 15 Decedent's Education (Specify only highest grade Completed) 15 Decedent's Education (Specify only highest grade Completed) 15 Decedent's Education (Specify only highest grade Completed) 15 Decedent's Education (Specify only highest grade Completed) 15 Decedent's Education (Specify only highest grade Completed Compl		10	Of. Zip Code	10g C	itizen of What Cou	untry?
200 PAULETTE ROAD  1 Wilson State of Part In U. Wilson December Ever in U. 5. 13. Was December of Hispanic Pright? Specify 'Tes or No Yes, specify (Chesh, Microat) Prights of Specify (Pright Prights of Part In United States of Part In United Stat				1	USA	
11 Morfald Safetts 12 New Married 2 Morfald 13 Workers 41 Vess 2 X No specify 14 Section (Specify only highest grade completely 15 Decadent's Standant (Specify only highest grade completely 21 DND 21 To Father's Name (First, Middle, Last)  15 DWARD BLUE 11  15 ENDWARD BLUE 11  15 ENDWARD MILLER / WOTHER 20 Name of Control of Specify 21 Section (Specify only highest grade completely 22 Section (Specify only highest grade completely) 23 Married of Disposition 15 Enter America Name (First, Middle, Last)  15 ENDWARD MILLER / WOTHER 20 Name of Control of Disposition 15 Enter America Name (First, Middle, Last)  15 ENDWARD MILLER / WOTHER 20 Name of Control of Disposition 15 Enter America Name (First, Middle, Last)  16 Decadent's Standant Name (First, Middle, Last)  17 Feather's Name (First, Middle, Last)  18 Morfald Standant Name (First, Middle, Last)  19 VOLANDA MILLER / WOTHER 20 Name of Control of Disposition 19 Enter America Name (First, Middle, Middlen Surname)  10 Enter America Name (First, Middle, Middlen Surname)  11 Section of Standant Name (First, Middle, Middlen Surname)  12 VOLANDA MILLER / WOTHER 20 Name of Control of Disposition 14 Decaded of Disposition 15 Enter Middle, Last only Control of Control of Standant Name (First, Middle, Middlen Surname) 21 Symptom of Control	2009 PAULETTE ROAD					
New York Married   Work Married   Work Companies   No   Work Com			ecedent of Hispanic Origin? (Species Origin?)	ecify Yes or No-		rican Indian, Black,
Wes   Set No.   Specify   Development   Set Service   Set No.   Specify   Development   Set Service   Set No.   Specify   Development   Set Service   Set No.   Specify   Development   Set No.   Specify   Development   Set No.   Set No.   Set No.   Set No.   Specify   Development   Set No.   Se		447	specify Cubart, Mexican, 1 denot	rticali, ctc./		7.07
15. Decedent's Education (Specify ofly hypinal grade completed) Elementary/Spacordary (0.12) College (1.4 of 51) 2ND  77. Father's Name (First, Middle, Lass) EDWARD BLUE III 159a Informatic Name/Belliocating (Type, First) 150 Monitory Name (First, Middle, Lass)  YOLANDA MILLER  YOLANDA MILLER  YOLANDA MILLER  YOLANDA MILLER  YOLANDA MILLER  YOLANDA MILLER  150 Member of Specify 1 National 2 Information State Office Specify 1 National 2 Information State Office Specify 2 Name and address of Facility 1 National 2 Information State Office Specify 2 Name and address of Facility 1 National 2 Information State Office Specify 2 Name and address of Facility 1 National Specific Office Specify 2 Name and address of Facility 1 National Specific Office Specify 2 Name and address of Facility 1 National Specific Office Specify 2 Name and address of Facility 1 National Specific Office Specify 2 Name and Address of Facility 2 Name and Address of Facility 2 Name and Address of Facility 3 National Specific Office Specify 3 National Specific Office Specify 3 National Specific Office Specify 4 National Specific Office Specify 4 National Specific Office Specify 3 National Specific Office Specify 4 National Specific Office Specify 4 National Specific Office Specify 4 National Specific Office Specify 4 National Specific Office Specify 4 National Specific Office Specify 4 National Specific Office Specify 4 National Specific Office Specific Office Specific Office Specific Office Specific Office Specific Office Specific Office Specific Office Specific Office Specific Office Office Specific Office Specific Office Specific Office Specific Office Office Specific Office Specific Office Office Specific Office Office Specific Office Office Specific Office Office Specific Office Office Specific Office Office Specific Office Office Office Specific Office Office Specific Office Office Specific Office	3 Widowed 4 Divorced If Yes, Give Year		es 2 X No specify:		Specify: B1	JACK
STUDENT   Teacher's Name (First, Mode, Last)   STUDENT   Teacher's Name (First, Mode, Last)   Teacher's Name (First, Mod	or Dates:	ompleted) 16a, Decedent's	Usual Occupation (Give kind of w	ork done 16b	. Kind of Business	/Industry
2.   The part is Name (First, Middle, Last)   The Mother's Name (First, Middle, Mattern Strainer)		during				
17. Fether's Name (First, Midde, Last) 17. Fether's Name (First, Midde, Last) 17. Fether's Name (First, Midde, Last) 17. Fether's Name (First, Midde, Last) 17. Fether's Name (First, Midde, Last) 18. Mailing Address (Sizeet and Number or Bruil' Rode Number, City or Town State, Zip Code) 19. Paul ETTE RD, DUNDALK, MD 21222 20.0 Palect of Disposition (Name of countrie) 20.0 Palect of Disposition (Name of countrie) 21. Signature of Larger's Speciety 22. Signature of Larger's Speciety 23. Signature of Larger's Speciety 24. Donation 5   Other Speciety 25. Signature of Larger's Speciety 26. Place of Disposition (Name of countrie) 27. Amendad doses of Facility 28. Larger's Speciety 29. Larger's Midde, Last on John State 29. Place of Disposition (Name of countrie) 29. Larger's Midde, Last on John State 29. Very Larger's Speciety 29. Larger's Midde, Last on John State 29. Very Larger's Speciety 29. Larger's Midde, Midden Survained Countries 29. Very Larger's Speciety 20. Larger's Midden, Midde	Ziomonia, i		<del></del>		STUDENT	Г
PENARD BLUE III  19a. Informatic Namer Relationship (type, Pret.)  19a. Informatic Namer Relationship (type, Pret.)  19b. Mailing Address (Steel and Number or Rural Route Number, City or Town, State, Zip Code)  20c PAULETTE RD, DUNDALK, MD 21222  20c PauleTTE RD, DUNDALK, MD 21222	2ND	STODE		(First Mindale Marks)		
19th Informatis Name/Relationship (Type, Pint.)  19th Informatis Name/Relationship (Type, Pint.)  19th Informatis Name/Relationship (Type, Pint.)  19th Informatis Name/Relationship (Type, Pint.)  19th Informatis Name/Relationship (Type, Pint.)  19th Informatis Name/Relationship (Type, Pint.)  200 Place of Department of Part Informatis Name/Relationship (Type, Pint.)  20b Place of Department of Part Informatis Name/Relationship (Type, Pint.)  20b Place of Department of Part Informatis Name/Relationship (Type, Pint.)  20b Place of Department of Part Informatis Name/Relationship (Type, Pint.)  20b Place of Department of Part Informatis Name/Relationship (Type, Pint.)  20b Place of Department of Part Informatis Name/Relationship (Type, Pint.)  21th Informatis Causes of Pacifity (Type, Pint.)  22th Informatis Causes of Pacifity Horizontal Information (Type, Pint.)  22th Informatis Average (Type, Pint.)  22th Informatis Causes of Pacifity Heriother Average (Type, Pint.)  22th Informatis Causes of Pacifity Heriother Name of Address of Facility Heriother The Model of dying, such as cardiac or respiratory arrest, shock, or heart Apartment of Pacific Information (Type, Pint.)  22th Informatis Causes on aceth line.  22th Informatis Causes on aceth line.  22th Informatis Causes on aceth line.  22th Informatis Causes on aceth line.  22th Informatis Causes on aceth line.  22th Informatis Causes of Pacifity (Type, Pint.)  22th Informatis Causes on aceth line.  22th Informatis Causes on aceth line.  22th Informatis Causes of Pacifity (Type, Pint.)  22th Informatis Causes on aceth line.  22th Informatis Causes on aceth line.  22th Informatis Causes on aceth line.  22th Informatis Causes on aceth line.  22th Informatis Causes on aceth line.  22th Informatis Causes on aceth line.  22th Informatis Causes on aceth line.  22th Informatis Causes on aceth line.  22th Informatis Causes on aceth line.  22th Informatis Causes on aceth line.  22th Informatis Causes on aceth line.  22th Informatis Causes on aceth line.  22th Informatis Cau	17. Father's Name (First, Middle, Last)					
Sequentially ist conditions, if any leading to immediate events resulting in death) Last   Due to (or as a consequence of)   Due to (or as a	POWARD BILIE TIT					
YOLANDA MILLER / MOTHER  200 Method of Disposition    Special Section of Composition   Date	19a. Informant's Name/Relationship (Type, Print )					te, Zip Code)
20. Method of Disposition 1 (Xigurial 2   Command of Comments of Line   Command of Comments of Line   Command of Comments of Line   Command of Comments of Line   Command of Comments of Line   Command of Comments   Command of Comments   Command of Comments   Command of Comments   Command of Comments   Command of Comments   Command of Comments   Command of Comments   Command of Comments   Command of Comments   Command of Comments   Command of Comments   Command of Comments   Command of Comments   Command of Comman		HER 2009	PAULETTE RD,	DUNDAL	K, $MD$ 2	1222
1   Neural 2   Cremation 3   Removal from State   A/15/2006   1   Constitution   Complication	TODANDA MITUUDIA		n (Name of cemetery,	Date 20	c. Location - City o	or Town, State
4 Donalion 5 Diter Specify 21 Signature of Funder Service Licenses 22 Name and Address of Facility 4600 LIBERTY HEIGHTS AVE, BAITIMORE, MD 4600 LIBERTY HEIGHTS 4600 LIBERTY HEIGHTS 4600 LIBERTY HEIGHTS 4600 LIBERTY HEIGHTS 4600 LIBERTY HEIGHTS 4600 LIBERTY HEIGHTS 4600 LIBERTY HEIGHTS 4600 LIBERTY HEIGHTS 4600 LIBERTY HEIGHTS 4600 LIBERTY HEIGHTS 4600 LIBERTY HEIGHTS 4600 LIBERTY HEIGHTS 4600 LIBERTY HEIGHTS 4600 LIBERTY 4600 LIBERTY HEIGHTS 4600 LIBERTY 4600 LIBERTY HEIGHTS 4600 LIBERTY 4		arematen, or other	place) 4/15	/2006		
22 Name and Address of Facility 4600 LIBERTY HEIGHTS AVE, BAITIMORE, MOWELL FUNERAL HOME 21207  23 Part VEnter this death or complicated by the foliation of the control of			CEMETERY 4/	7/06	LANSDOW	NE, MD
23. Yan y Enter the goldeste, or complications that descended from the first the mode of dying, such as cardiac or respiratory arrest, shock, or heart and particular for the mode of dying, such as cardiac or respiratory arrest, shock, or heart and particular for the mode of dying, such as cardiac or respiratory arrest, shock, or heart and particular for the mode of dying, such as cardiac or respiratory arrest, shock, or heart and particular for the mode of dying, such as cardiac or respiratory arrest, shock, or heart and particular for the mode of dying, such as cardiac or respiratory arrest, shock, or heart and particular for the mode of dying, such as cardiac or respiratory arrest, shock, or heart and particular for the mode of dying, such as cardiac or respiratory arrest, shock, or heart and particular for the mode of dying, such as cardiac or respiratory arrest, shock, or heart and particular for the mode of dying, such as cardiac or respiratory arrest, shock, or heart and particular for the mode of dying, such as cardiac or respiratory arrest, shock, or heart and particular for the mode of dying, such as cardiac or respiratory arrest, shock, or heart and particular for the mode of dying, such as cardiac or respiratory arrest, shock, or heart and particular for the mode of dying, such as cardiac or respiratory arrest, shock, or heart and particular for the mode of dying, such as cardiac or respiratory arrest, shock, or heart and particular for the mode of dying, such as cardiac or respiratory arrest, shock, or heart and particular for the particular for the particular for the particular forms and particular for the particular for an acceptance of the forms and particular forms and particular for the particular forms and particular forms and particular forms and particular forms and particular forms and particular forms and particular forms and particular forms and particular forms and particular forms and particular forms and particular forms and particular forms and particular forms and particular forms an						•
Approximate interval between the properties of t	The state of the s	1/2 16	את זע עשמשמדו הה	TCHTC A	MEKAD U	THORE MI
Committee   Comm	// www 0 //	40	mode of dving such as cardiac o	r respiratory arrest,	shock, or heart	Approximate Interval
Townsing complicated by Hypothermia Due to (or as a consequence of):  Due to (or as consequence of):  Due to (or as consequence of):  Due to	23a Part / Enter the disease, or complications that caus	ed-me death. Comot enter the	mode of dying, business out and a			
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death). Last  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	Drawning con	nplicated by Hypotherm	nia			Death
Due to (or as a consequence of):    UNPENDED						
Due to (or as a consequence of):    UNPENDED	h					
Course Enter Underlying Cause Disease or injury that initiated  UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	Sequentially list conditions,	onsequence of):				
Due to (or as a consequence of):   Chiesease of injury of minimate events resulting in death) Last   Last	cause. Enter Underlying Cause					
UNPENDED    AMENDED   Item#20b, perFH, 0854, 4/19/06 TT	(Disease of injury that initiated	onsequence of):				
UNPENDED    AMENDED   Item#20b, perFH, G854, 4/19/06 TT   IF FEMALE:   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day   Year   1   Live birth   2   Dinknown   1   Live birth   2   Dinknown   1   Live birth   2   Dinknown   1   Live birth   2   Dinknown   23e. Did tobacco use contribute to the cause of death?   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy   1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy   1   Yes   2   No						
FEMALE:   23b. Was decedent pregnant in the past 12 months?   1		ter#20h.nerFH.085	4.4/19/06 TT			
25. Was decedent pregnant in the past 12 months?  1			1, 1, 12, 00 11		23d Data of daling	erv
yes 2 months?  1			I de ath 3 Extenie pregn	ancv		
Part II. Other significant conditions  23e. Did tobacco use contribute to the cause of death?  1				u,		,
25. Was case referred to medical examiner?  1			er (Specify)			
25. Was case referred to medical examiner?  1	Tes 2 No 9 Olikilowii 9 Unknow			one bidart.	non una nontribute	to the cause of death?
24a. Was an autopsy findings available prior to completion of cause of death?  25. Was case referred to medical examiner?  1		eath but not resulting in the un	derlying cause given in Part I.			
27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) River  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) River  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  20c. Injury at Work? FOUND: 1 Yes 2 No No Normal Norma	•			1 Yes	2 No 3 P	robably 4 Unknown
27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) River  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) River  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  20c. Injury at Work? FOUND: 1 Yes 2 No No Nome and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner:  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water				24a. Was an	24b. Were	autopsy findings available
27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) River  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and ditle of certifier  20c. Manner of Death 1 Natural 5 Pending Investigation 28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Describe how injury occurred Subject drowned in cold water  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Describe how injury occurred Subject drowned in cold water  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury in the subject drowned in cold water  28d. Describe how injury in						
27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) River  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) River  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  20c. Injury at Work? FOUND: 1 Yes 2 No No Nome and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner:  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water						
27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) River  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) River  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number 29d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) River  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started.  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  April 11, 2006  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner  111 Penn Street, Baltimore, MD 21201			26 Diago of Dooth (Chook			lamand
27. Manner of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined (Specify) River  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and ditle of certifier  20c. Manner of Death 1 Natural 5 Pending Investigation 28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Describe how injury occurred Subject drowned in cold water  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Describe how injury occurred Subject drowned in cold water  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury occurred Subject drowned in cold water  28d. Describe how injury in the subject drowned in cold water  28d. Describe how injury in	25. Was case referred to medical		Other:		-id 6 0	har Coons
O.C.M.E. April 11, 2006  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		patient 2 ER/Outpatient	3 DOA Nursi	,	-	mer: Scene
O.C.M.E. April 11, 2006  30. Name and address of person who completed cause of death (ttem 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	27. Manner of Death 28a. Date of	Injury 28b. Time of Inj	jury 28c. Injury at Work?			tor
O.C.M.E. April 11, 2006  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	1 Natural 5 Pending FOUND:	FOUND:	1 Yes 2 ✔ No	Subject drown	ied iii Cold Wai	lei
O.C.M.E. April 11, 2006  30. Name and address of person who completed cause of death (ttem 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	2 Accident Investigation Apr 10, 26		for the office of the state of	39f Location (Str	ot and Number or	Rural Route Number City
O.C.M.E. April 11, 2006  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	3 Suicide 6 Could not be 28e. Place	of Injury - At home, farm, street	; factory, office building, etc.	as Tours Stat	01	
O.C.M.E. April 11, 2006  30. Name and address of person who completed cause of death (ttem 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	4 Homicide determined (Specify)	River		Bear Creek R	ver at 2013 P	aulette Road, Dunda
O.C.M.E. April 11, 2006  30. Name and address of person who completed cause of death (ttem 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	29a. Certifier 1 Certifying Physician: To the best	of my knowledge, death occurr	ed at the time, date and place, ar	nd due to the cause(	s) and manner as s	started.
O.C.M.E. April 11, 2006  30. Name and address of person who completed cause of death (ttem 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	(Check only one) 2 Medical Examiner: On the basis of	examination and/or investigation	on, in my opinion, death occurred	at the time, date an	d place, and due to	o the cause(s)
O.C.M.E. April 11, 2006  30. Name and address of person who completed cause of death (ttem 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	and manner sta	ated.	,			
30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	29b. Signature and title of certifier					
30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	(1408) -	MP	O.C.M.E.		April 11, 2006	
Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	Cine 18	(				
/ III Tradio III -			treet Baltimore MD 2120	01		
21. Date filed (Month, Day, Year) 32 Segistrar's Signature		Addition 111 Femily	acot, Datalloro, MD 212			
	31. Date filed (Month, Day, Year)	jistrar's Signature	- 2			

Registrar

APR 1 3 2005 - Colored - 45



DHMH 17 Rev 1/2001 OCME 10/2003

			1 - For State Registrar	State of Maryland		rtment of He			iene	1500
	Dhariai		1. Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici /Medio		TATRICIA	BOLY	ARI			APRIL 1	1 2006	9:30 M
1	Examir	ner		ISHIRE (	CT		ocation of Death ALK  If Under 24 Hrs.	18:11	-	MORE
	Funeral Director			7. Age (In yrs. last	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 1950 9. Bir	thplace (State or Foreign ountry)
	g ,		Usual Residence of Decedent		Ŧ					
	Aaryia   •hov	ō	10a. State 10b. County	-	Town or Loc					10d. Inside City Limits 1 Tyes 2 No
	28a-f	Director	mD BAUTIN  10e. Street and Number	ICEE DU	NDAL	10f. Zip Code		10	og. Citizen of What Co	
	3a or		109 HIGHS	TERE CT			1222		USA	ourity;
	r deat	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	. 13. W	as Decedent of Hisp Yes, specify Cuban,	panic Origin? (Sp Mexican, Puerto	ecify Yes or No-	14. Race - Ame Black, Whit	
36	be filed within 72 hours after death with the Maryland stall tyrgiene.  de other than "neturel", or iteme 23e or 28e-f ehow event, the Medical Examinating the rediffed at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give			Specify:	7.110411, 0(0.)		HITE
215-0036	2 hour	ed b	15. Decedent's Edu	Year or Dates:	16a. Decede	ent's Usual Occupati	ion		16b. Kind of Business	
215	thin 72	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give k life. D	ind of work done du O NOT use retired)	ring most of work	ing		_
CA	filed wil Hygien sther th	Соп	12 Yes.		<del> </del>	LOUSEW			Hom	E
Maryland		Be	17. Father's Name (First, Middle, Last)	DEORICK		1	8. Mother's Name	e (First, Middle, M		1000
Z	d 2 should be the and Menta the marked traumatic events.	2	JOHN EARL  19a. Informant's Name/Relationship (Ty)		19b. Mailing	Address (Street an			MACTIA City or Town, State,	7:- 0:- 4:3
	d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2 d 2		CHARLES BOLY	ARD HUSBAUD					NDACK MO	
altimore,	ges 1 and tof Heali if item 2 or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	netery, cremi	ition (Name of atory or other place)	APLI	1-15	0c. Location · City or	
ţ	Pag nen nen ant:		4 □ Donation 5 □ Other (Specify)	はもよっ	IEW	CLEMA	700g)	2006	BALTIMOS	
Bal	permit. Departn Imports any inju		21. Signature of Funeral Service License	(	20				DUND .	alk.
	_		23a. Part1. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death.	not enter					Approximate
	Priysician	66 1	Immediate Cause (Final disease or condition	metaltat		Colon C				Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a conseque		30.010	300(00)			2/2 450013
	Examiner	ē	Sequentially list conditions	Due to (or as a conseque						
V	uted s insit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	nce or;					
ó	be executed sicien and burial-transit	Еха	resulting in death) Last	Due to (or as a conseque	nce of):					
8760	cete be executed bhysicien and the burial-transit	dicai								
9 ×	ding p	/Mec	IF FEMALE:	3c. If yes, outcome of pregnance	w					
Вох	leath certifi ettending for use as	cian	23b. Was decedent pregnant in the past 12 months?  1 \( \subsection \text{Yes} \) 2 \( \subsection \text{No} \)	1 Live birth 2 Fetal de 4 Pregnant at time of dea	eath 3 □E	ctopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
P.O.	at the de by the tached	Physician/Me	9 Unknown	9□ Unknown						
S,	es tha igned be de	<u>م</u>	Part II. Other significant conditions con	tributing to death but not resulti	ing in the und	lerlying cause given	in Part I.		acco use contribute to	
Vital Records,	v requir been si should	Completed						1 Tes	s 2.02√No 3Pr	obably 4 Unknown
Rec	The law ate has t page 2 s	mpl						24a. Was an autopsy perform	prior to	stopsy findings available completion of cause of
		0	25. Was case referred to medical				S Place of Death	1 Yes 2	□No 1 □ Yes	2 □ No
	S S S	To B	examiner? 1 Yes 2 No	ospital: 1   Inpatient 2   EF	R/Outpatient	3□ DOA Other:			nce 6 □Other (Spe	cify)
	و قو م		27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury a Work?		28d. Describe how		
Division	Attending ir death. ector: After by the fune	Icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	On Place of laine, At ham	- (		s 2 No	206 Laureina (Cen		
Θ	il or A after Direct Jin by	Certification;	4 Homicide determined	28e. Place of Injury - At hom- building, etc. (Specify)	e, ≀arm, stre€	вт, тастогу, опісе		City or Town,	eet and Number or Ru State)	ural Houte Number,
	To the Hospital or Attendir within 24 hours after death. To the Funerel Director: At completely filled in by the fur		29a. Certifier 1 Certifying Phys	ician: To the best of my knowledger: On the basis of examination	edge, death o	occurred at the time,	date and place,	and due to the car	use(s) and manner as	stated.
	the H hin 24 the F	Medical	Une)	and manner stated.	n and/or inve					
	5 7 K 7		29b. Signature and title of certifier	M.D.		29c. License r	65.29C	) A	d. Date signed (Mont	2006
	J.	1	30. Name and address of person who con	mpleted cause of death (Item 2)	3a) (Type P	rint)	^		1	
	. 7			9114 phila	delpi	via Roac	103 th X	t, Bal	timore	2006 MD2123C
	Sta		31. Date filed (Month, Day, Year)	32. Figistrar's Signatur		and a				
	Registr	ar	APR 1 3 200	10 Paragram	7" 000	The same of the sa				